

Rece^d 8-31-83
D.L.W. 8-31-83
TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at any time.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 22614				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			8-31-83							3:55 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			Black			6 25 02			81			MONTHS DAYS		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 18 HRS		
MD			USA						Talbot			MONTHS DAYS		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL, FACILITY, OR STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton			Marian			Clerk Typist			Retired					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS				
13a. STATE MD			13b. COUNTY Talbot			13c. CITY OR TOWN EASTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Ave. EAST. 21601			
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE					
Aaron			Murray			SUSAN			Murray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT Gwenville Brittingham			ADDRESS Port St EASTON					
NO														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1539 Metastatic colon carcinoma										1976				
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
Paroxysmal atrial fibrillation arterial embolism, left leg.														
19a. DATE OF OPERATION 8-18-83 8-22-83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colostomy Prolapsed Colostomy			19c. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLIED OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 3-17, 1980, to 8-31, 1983, that (1) (we) last saw the deceased alive on 8-31, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8-31-83				
22b. SIGNATURE Robert W. Trever, M.D.										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS RD 3 Box 297 Easton, Md. 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9/3/83			23c. NAME OF CEMETERY OR CREMATORIAL Richards			23d. LOCATION CITY OR TOWN Talbot					
24. FUNERAL DIRECTOR NAME			ADDRESS Evelyn Dashiell P.O. Box 297 Easton MD			25a. DATE REC'D. BY REGISTRAR SEP 9 1983			25b. REGISTRAR'S SIGNATURE Talbot					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND 83 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 22615											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR		
ANNETTA ANDERSON									8 7 83		
3. SEX FEMALE		4. RACE II 9		5. DATE OF BIRTH MONTH DAY YEAR 3 - 12 - 1914		6. AGE (IN YEARS LAST BIRTHDAY) 69		2b. HOUR 12:20 A IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT		MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING CENTER-THE PINES		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home					
13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Washington Street 21601			
14. FATHER'S NAME FIRST Raymond		MIDDLE Beucler		15. MOTHER'S MAIDEN NAME Ellen N. Holmes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 138-22-2456-		17. INFORMANT Sylvan Beucler, Milton, Del.		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>severe degenerative dementia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2989											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Seizure disorder, retinitis pigmentosa</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> , 19 <u>85</u> , to <u>8-7</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>7-28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.											
22b. SIGNATURE <u>P. B. Sanchez</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7 Aug 83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P. B. Sanchez</u>		22e. ADDRESS 322 Commerce Dr Easton									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATED</u>		23b. DATE <u>8/9/83</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>DENTON</u>		23d. LOCATION CITY OR TOWN STATE <u>DENTON, MD</u>					
24. FUNERAL DIRECTOR <u>X MOORE FUNERAL HOME</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 12 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return to the hospital or attending physician.

Death, Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use as the burial permit. Then please remove the paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner may be required to examine the body.

MEDICAL CERTIFICATION

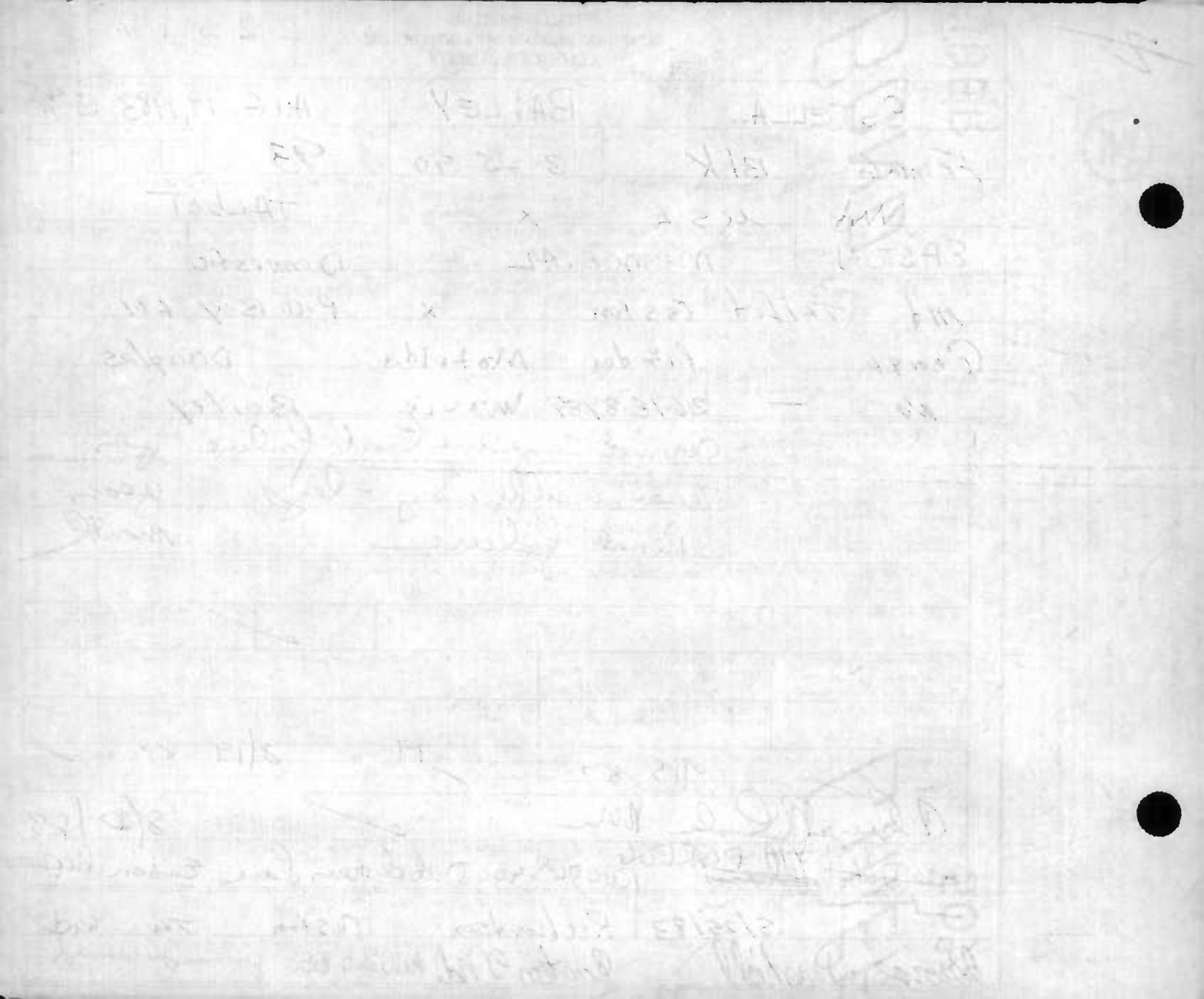
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22616					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2d. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
IDA A. RING									8		31	83	8 05	8 A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female			Cau			MONTH DAY YEAR July 20, 1893			90		YEARS		MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland			USA						TALBOT						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Easton			EASTON MEMORIAL			Housewife			-----						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE						
Maryland			Talbot		Wittman		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21676						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Andrew Kirk			Amelia Euler												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			213-48-8120			Bernice A. Steiner, Wittman, Md.			21676						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN DEATH AND MORTUAR					
IMMEDIATE CAUSE (a) <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										2 days					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary edema</u>										6 days					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASHD</u>										many years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>8-25</u> , 19 <u>83</u> , to <u>8-31</u> , 19 <u>83</u> , that (2) (we) last saw the deceased alive on <u>8-30</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>8-31-83</u>					
22b. SIGNATURE <u>Stephen P. Farney</u>			22d. DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22e. ADDRESS 21601															
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Farney, M.D.			22g. ADDRESS Dutchman's Lane, Easton, Maryland												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Sept 2, 1983			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cem.			23d. LOCATION CITY OR TOWN Randallstown, Balto		COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <u>James E. Leonard, St. Michaels</u>			ADDRESS MAY 13 1983			25a. DATE REC'D. BY REGISTRAR MAY 13 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked on Item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22611							
										REG. NO.							
1. DECEASED NAME [TYPE OR PRINT]			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ESTELLA									BAILEY			AUG. 19, 1983				5:45 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR				IF UNDER 24 HRS	
Female			BLK			MONTH 3 DAY 25 YEAR 90			93			MONTHS DAYS				HOURS MIN.	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			TALBOT					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
EASTON			MEMORIAL			Domestic			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			31601					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
MD			TALBOT			EASTON						P.O. Box 611					
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
George			Matilda			216-18-8989			Wavie			Bailey					
18. CAUSE OF DEATH (Enter only one cause per line for item 18, part 1 or part 2) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			ADDITIONAL INTERVAL BETWEEN ONSET AND DEATH								
No			Chronic congestive heart failure			Ventricular insufficiency - leg			yes			year					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												year month					
DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19-79 to 19-80, that (I) (we) last saw the deceased alive on 8/13/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME									8/10/83								
P. GREGORY RHODES			400 Dabdin's Lane, Easton MD			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STAFF			
1			5/25/83			Richardson			EASTON			MD					
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
George Dashill			EASTON MD			AUG 25 1983			George Dashill								



STATE OF MARYLAND 83 22618
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

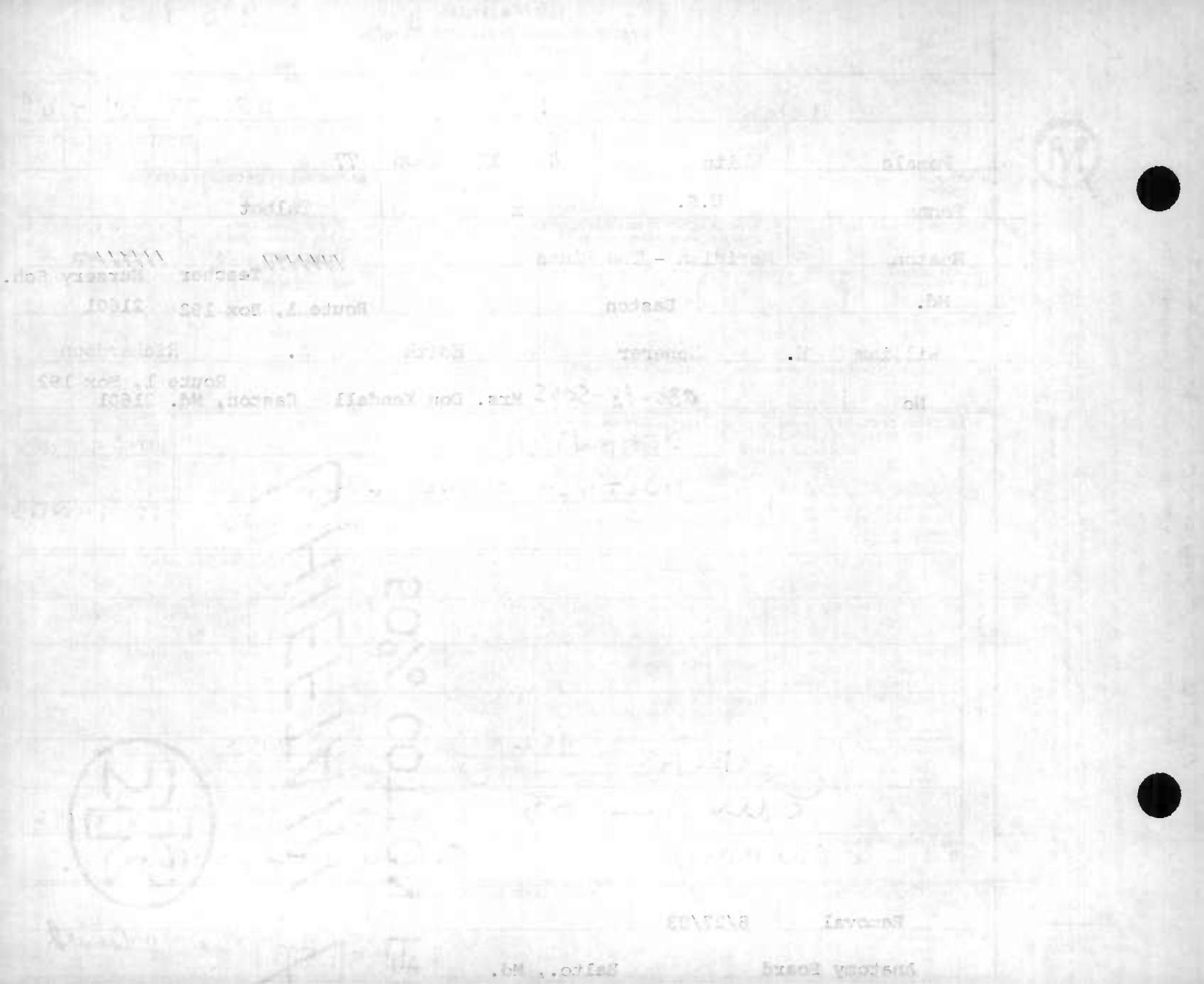
1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Helen</i>	MIDDLE <i>Berry</i>	LAST	2a. DATE OF DEATH MONTH YEAR	2b. HOUR 08 27 83 4:42 A	
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH 4 DAY 12 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot		
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian - The Pines			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unknown		12b. KIND OF BUSINESS OR INDUSTRY Teather	
13a. STATE Md.		13b. COUNTY Easton		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route 1, Box 192
14. FATHER'S NAME FIRST William		MIDDLE H.	LAST Scherer	15. MOTHER'S MAIDEN NAME FIRST Edith		MIDDLE A.	LAST Richardson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 030-18-5055		17. INFORMANT Mrs. Don Kendall		ADDRESS Route 1, Box 192		
						Easton, Md. 21601		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DEMENTIA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ONE YEARS			
2900 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b) MULTIPLE CEREBROVASCULAR						
		(c) ACCIDENTS			18 MONTHS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) this hospital attended the deceased from 1982 saw the deceased alive on 9/26/83, and that in (my) our opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>C RW Brain M.D.</i>		22c. DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>8/27/83</i>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) C RW Brain		22f. ADDRESS Easton, Md. 21601						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/27/83		23c. NAME OF CEMETERY OR CREMATORIAL ✓		23d. LOCATION CITY OR TOWN		
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR AUG 31 1983		25b. REGISTRAR'S SIGNATURE <i>Reg. C. 83</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 22619			
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)			3. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	8 29 83			
Clementine L. Butler					4:15 PM			
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 61	7. HOUR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vienna, Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Talbot	10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Rhodesdale	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. 1, Box 44C 21659			
14. FATHER'S NAME FIRST George D. Lee		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Grace R. Murphy	MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-18-6561		17. INFORMANT Gordon E. Butler, Rt. 1, Box 44C, Md. 21659	ADDRESS Rhodesdale,			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b and c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360		DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days				
DUE TO, OR AS A CONSEQUENCE OF (c) Massive CVA		2 weeks						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a End Stage Emphysema complicated by dysphagia, A500								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from now the deceased died on 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not remove the body after death.		19 81 to 8/29/83, the (1) (we) last						
22b. SIGNATURE Donald Lewers, M.D.		DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/29/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Lewers, M.D.		22e. ADDRESS Easton, Md. 21601						
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE Sept. 1, 1983	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	23d. LOCATION CITY OR TOWN Bethel, Md.				
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home		25a. DATE REC'D. BY REGISTRAR Federalsburg, Md.	25b. REGISTRAR'S SIGNATURE John J. Canfield					

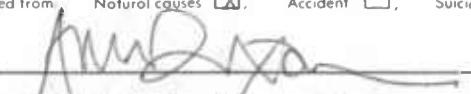
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Info. taken from Birth			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						22620					
1 - FOR STATE 9/16/83 kam REGISTRAR									REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
Linda Marie Butler						7.17.83					3:25 AM			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Female			Black		July 17, 1983		IF UNDER 1 YEAR			IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
Maryland			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Talbot			1 MONTHS 1 DAYS				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial - Easton						12a. STREET ADDRESS			MD. 21601		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland			Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			44 Graham Street				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Stanley Charles Butler						Jane Alva Lee Washington								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.						17. INFORMANT			ADDRESS		
									Info. from Birth, g					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>immaturity</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(b) <u>probable amnionitis</u>														
DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Ch. Jones</u> DEGREE														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						22f. DATE SIGNED 7-18-83					
CAROL M. GONZALEZ MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR NAME			Incinerated		Talbot - Easton Mem			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE John J. Conner			
								\$ SEP 16 1983						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	2b. MONTH	2c. DAY	2d. YEAR		
John			Sidney			Carey						<input checked="" type="checkbox"/>	8/28/83	19			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2e. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR				
Male	White	01 1947	36							8/28/83	19	4:15					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			Talbot County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Easton		Memorial Hospital								12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
14. FATHER'S NAME FIRST John		MIDDLE Sidney		LAST Carey, Sr.		15. MOTHER'S MAIDEN NAME FIRST Elizabeth			MIDDLE Nora		LAST Horseman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-56-5261		17. INFORMANT Mrs. Mabel Adams (Aunt) Route #3 Box 356, Millsboro, Del. 19966			ADDRESS										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure Disorder DUE TO, OR AS A CONSEQUENCE OF 7803 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE 														TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.														ADDRESS 111 Penn St., Balto., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/83		23c. NAME OF CEMETERY OR CREMATORIUM Smullen Cemetery			23d. LOCATION CITY OR TOWN Salisbury			COUNTY Wicomico		STATE Maryland					
24. FUNERAL DIRECTOR NAME Holloway Funeral Home, P.A. Salisbury, Md.		ADDRESS		25. DATE REG'D. BY DEPT. OF MARYLAND REGISTRATION SEP 2-1983													
20M 4/82																	

Verifi

1. *Chlorophytum comosum* (L.) Willd. (Liliaceae)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

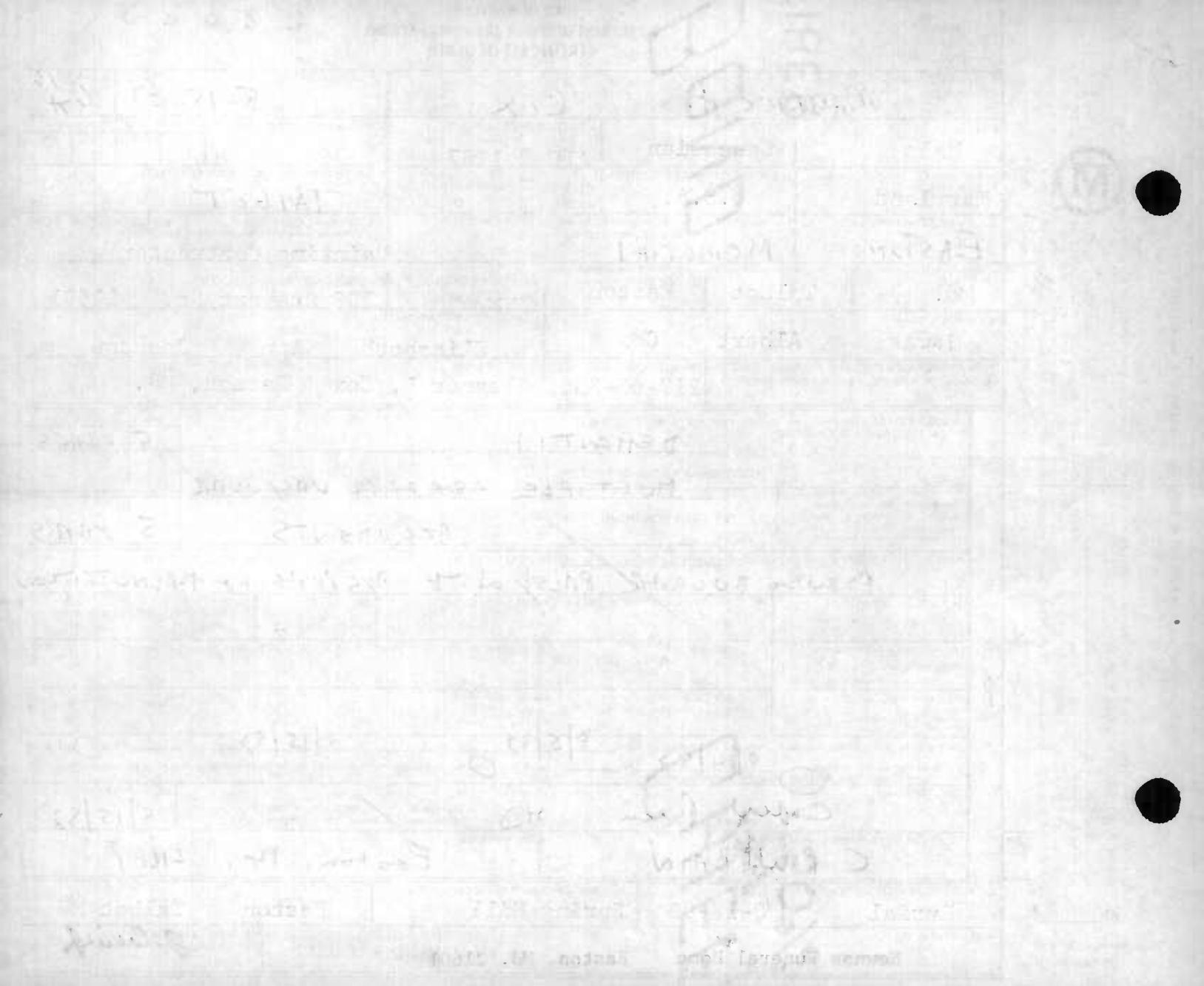
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22622					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Victor			Christopher			August 3 1983			5 A M						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			9 16 1914			68	MONTHS	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>	Talbot					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EASTON			Memorial Hospital			Machine Oper.			Plastic						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland			Caroline			Federalsburg			<input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD Fed., Md. 21632				
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME									
Howard			W. Christopher			Elizabeth C. Lord									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS						
Yes			WW 2			215-01-1187			Bessie Christopher			RFD Fed., Md. 21632			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4140 Cardiac Arrest/thrombosis										acute					
DUE TO, OR AS A CONSEQUENCE OF (b) ASTH															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
Severe COLD with Pulmonary Hypertension															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Aug 2 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										19 80 to 19 87 19 31					
22b. SIGNATURE Please Read Me										DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PGREGG RHODES MD.										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. ADDRESS 400 Dutchman's Lane - Easton, Md.										22f. DATE SIGNED 8/7/83					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8-5-83			23c. NAME OF CEMETERY OR CREMATORIAL Veterans-Beulah			23d. LOCATION CITY OR TOWN Hurllock COUNTY Dorchester STATE Md.						
24. FUNERAL DIRECTOR NAME Harvey Williams			ADDRESS Federalsburg, Md.			25. DATE REC'D. BY REGISTRAR AUG 8 1983			25. REGISTRAR'S SIGNATURE John G. Cawieck						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22023			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
MAURICE A. Cox						8-15-83			6 AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		Caucasian		AUG 2 1907			76						
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		U.S.A.					Talbot						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
EASTON		Memorial								Painting Contractor			
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 109 Stewart St. 21601			
14. FATHER'S NAME FIRST James		MIDDLE Albert		LAST Cox			15. MOTHER'S MAIDEN NAME FIRST Elizabeth			MIDDLE Ann			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO		16c. INFORMANT			17. INFORMANT Eleanor L. Cox			LAST Jackson ADDRESS Easton, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEMENTIA</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS			
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>MULTIPLE CEREBRO VASCULAR</u> (c) <u>ACCIDENTS</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>PSUDO BULBAR PALSY WITH DYSPHAGIA & MALNUTRITION</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET		CITY OR TOWN			
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <u>8/14/83</u> 19		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)								COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14/83</u> 19 to <u>8/15/83</u> 19, that (I) (we) lost saw the deceased alive on <u>8/14/83</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>C.R.W. Barn</u>		22c. DEGREE <u>MD</u>								22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>8/15/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C.R.W. Barn</u>		22e. ADDRESS <u>Easton, Md. 21601</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-18-83			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill			23d. LOCATION CITY OR TOWN Easton		23e. COUNTY STATE Talbot Md			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		25a. DATE REC'D. BY REGISTRAR AUG 19 1983								25b. REGISTRAR SIGNATURE <u>John Newnam</u>			
BP													
DHMH - 16 50M 4/83 (VRA 15, 4)													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO PAGE 5. FOR YOUR INFORMATION, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3 RETAIN PAGE 5 FOR YOUR INFORMATION. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REBURY.

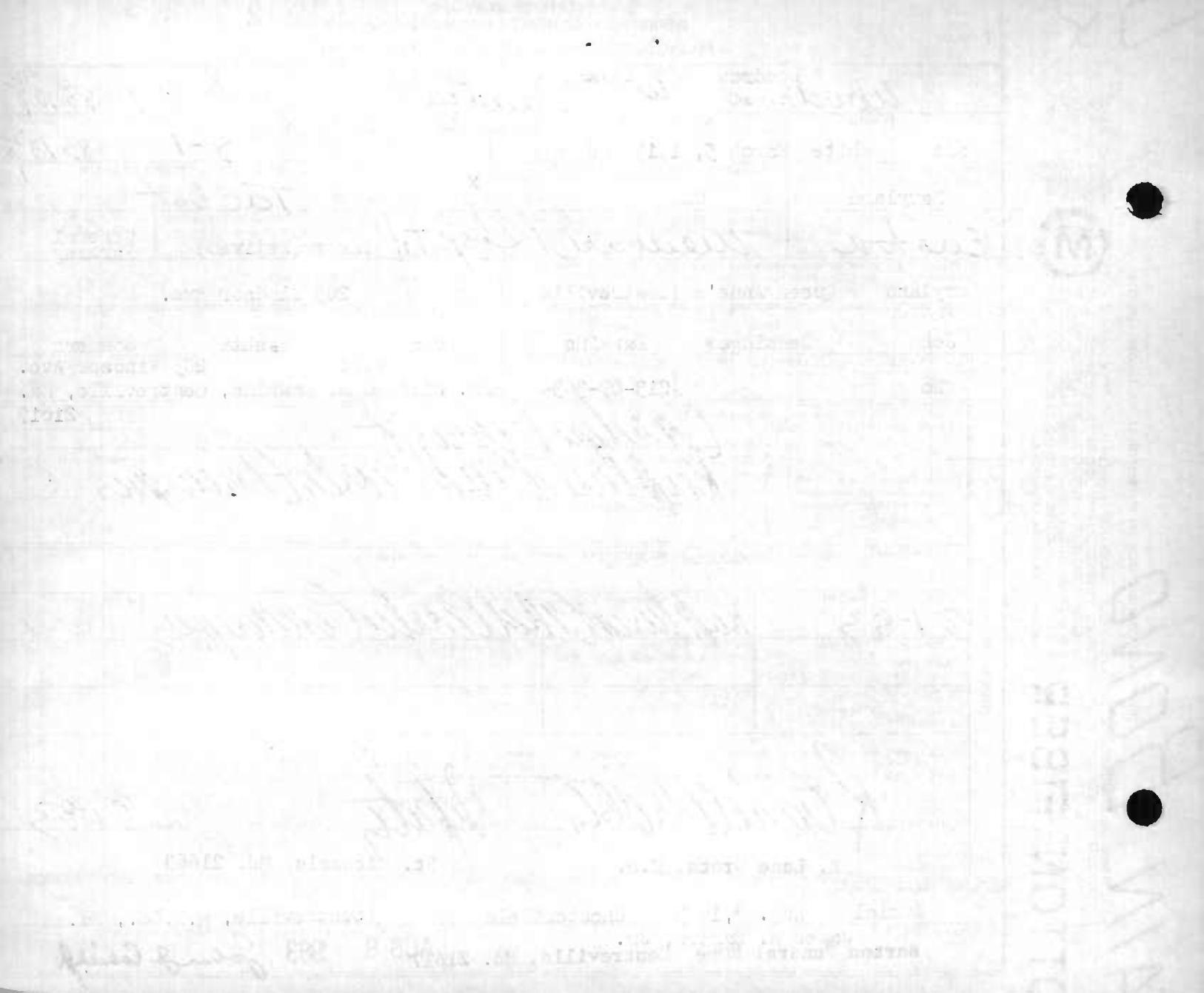
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22624										
												REG. NO.										
1. FOR 1- STATE REGISTRAR			FIRST Cheryl			MIDDLE Lynn			LAST Darling			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR							
(TYPE OR PRINT)			Cheryl Lynn			Lynn			Darling			<input checked="" type="checkbox"/> MONTH 8 <input type="checkbox"/> DAY 7 <input type="checkbox"/> YEAR 1983			2b. HOUR 2:15 2:15 AM							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS			8. IF UNDER 24 HRS. DAYS			9. DATE PRONOUNCED DEAD			2d. HOUR	
F			W			MONTH DAY YEAR			21 YRS.			MONTHS			HOURS MIN			8 7 1983			2d. HOUR 2:20 2:20 AM	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. CITIZEN OF WHAT COUNTRY?			12. MARRIED			13. NEVER MARRIED			14. WIDOWED			15. DIVORCED			16. BALTIMORE CITY OR COUNTY OF DEATH				
Md.			U.S.A.			<input checked="" type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			<input type="checkbox"/>			Talbot				
17. CITY OR TOWN OF DEATH			18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			21. KIND OF BUSINESS OR INDUSTRY										
EASTON			MEMORIAL Hospital			Md. Caroline			Denton			housewife			none							
22. STATE			23. COUNTY			24. CITY OR TOWN			25. INSIDE CITY LIMITS?			26. STREET ADDRESS			27. ADDRESS							
Md.			Caroline			Denton			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Deep Shore Road			21629							
28. FATHER'S NAME			29. MOTHER'S MAIDEN NAME			30. INFORMANT			31. ADDRESS			32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
FIRST Unknown			FIRST Ellen Luckett			James Darling			Denton, Md.													
33. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			34. SOCIAL SECURITY NO.			35. INFORMANT			36. ADDRESS													
no						James Darling			Denton, Md.													
37. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) <u>Multiple Severe Injuries</u>																						
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Auto accident</u> DUE TO, OR AS A CONSEQUENCE OF																						
(c) <u></u>																						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																						
38. DATE OF OPERATION			39. CONDITION FOR WHICH OPERATION WAS PERFORMED?									40. AUTOPSY?										
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
41a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			41b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			41c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			42. DATE OF INJURY STRUCK WALKING ON HIGHWAY													
41d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			41e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			41f. LOCATION STREET			41g. CITY OR TOWN			41h. COUNTY			41i. STATE							
42a. I certify that I took charge of the remains described above, held an			42b. Autopsy <input type="checkbox"/>			42c. Inspection <input checked="" type="checkbox"/>			42d. Inquiry <input type="checkbox"/>			42e. and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
43a. ACTUAL SIGNATURE <u>Louis S. Shultz</u>			43b. M.D. <u>Indp</u>			43c. TITLE (SPECIFY) MEDICAL EXAMINER			43d. DATE SIGNED <u>8-7-83</u>													
44a. EXAMINER'S NAME (TYPE OR PRINT) <u>Louis S. Shultz</u>			44b. ADDRESS <u>Easton Md</u>																			
45a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			45b. DATE <u>8-10-83</u>			45c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Greensboro Cemetery</u>			45d. LOCATION CITY TOWN <u>Greensboro</u>			45e. COUNTY <u>Caroline</u>			45f. STATE <u>Md.</u>							
46a. FUNERAL DIRECTOR NAME <u>John E. Boulas</u>			46b. ADDRESS <u>Greensboro</u>			46c. DATE REC'D. BY REGISTRAR <u>AUG 10 1983</u>			46d. REGISTRAR'S SIGNATURE <u>Joe J. Cade</u>													

THE BOSTONIAN 17

97

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DURATION IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN FORM PM-3. RETAIN FORM PM-3 WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 PRESTON STREET, BALTIMORE, MARYLAND.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.					
1- STATE REGISTRAR			STATE OF MARYLAND, DEPARTMENT OF HEALTH AND MENTAL HYGIENE									22625					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		DAWKINS			2a. DATE KNOWN OF DEATH ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
Woodrow		Wilson		W		DAWKINS		Woodrow Wilson DAWKINS			8-1	1983	10:30 AM	10:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male		White		March 5, 1917		66 yrs.		MONTHS		DAYS		8-1	1983	10:50 AM	10:50 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA		Talbot										Talbot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton		Almaire Hospital										Farmer (retired)			General Farming		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			MD.					
Maryland		Queen Anne's		Centreville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			205 Windsor Ave.			21617					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME			16. APPROXIMATE AGE BETWEEN ON DEATH						
John		Jennings				Dawkins		Nora			21617						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT			ADDRESS		
No		213-09-3034										Wife			205 Windsor Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for line 1a, and 1c.) PART I DEATH WAS CAUSED BY: 4413 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF 21617																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Ruptured Old Earlobe Anemia																	
19a. DATE OF OPERATION		19b. CONDITION OR DRUG WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
8-1-83		Ruptured Old Earlobe Anemia										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22. LOCATION STREET CITY OR TOWN COUNTY STATE											
21d. THE INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: R. Lane Wroth, M.D. TITLE (SPECIFY): M.D. MEDICAL EXAMINER DATE SIGNED: 8-1-83																	
23a. EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS: St. Michaels, Md. 21663															
R. Lane Wroth, M.D.																	
23b. BURIAL, CREMATION, REMOVAL (SPECIFY)		23c. DATE		23d. NAME OF CEMETERY OR CREMATORIAL		23e. LOCATION CITY OR TOWN			23f. COUNTY			23g. STATE					
Burial		Aug. 4, 1983		Chesterfield		Centreville, Q.A.C. Co., Md.											
24. FUNERAL DIRECTOR NAME		James H. Barton Jr.		Barton Funeral Home		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
						AUG 8 1983											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked of item 18, mark any injury, or other traumatic event, the medical examiner must be notified at 911)

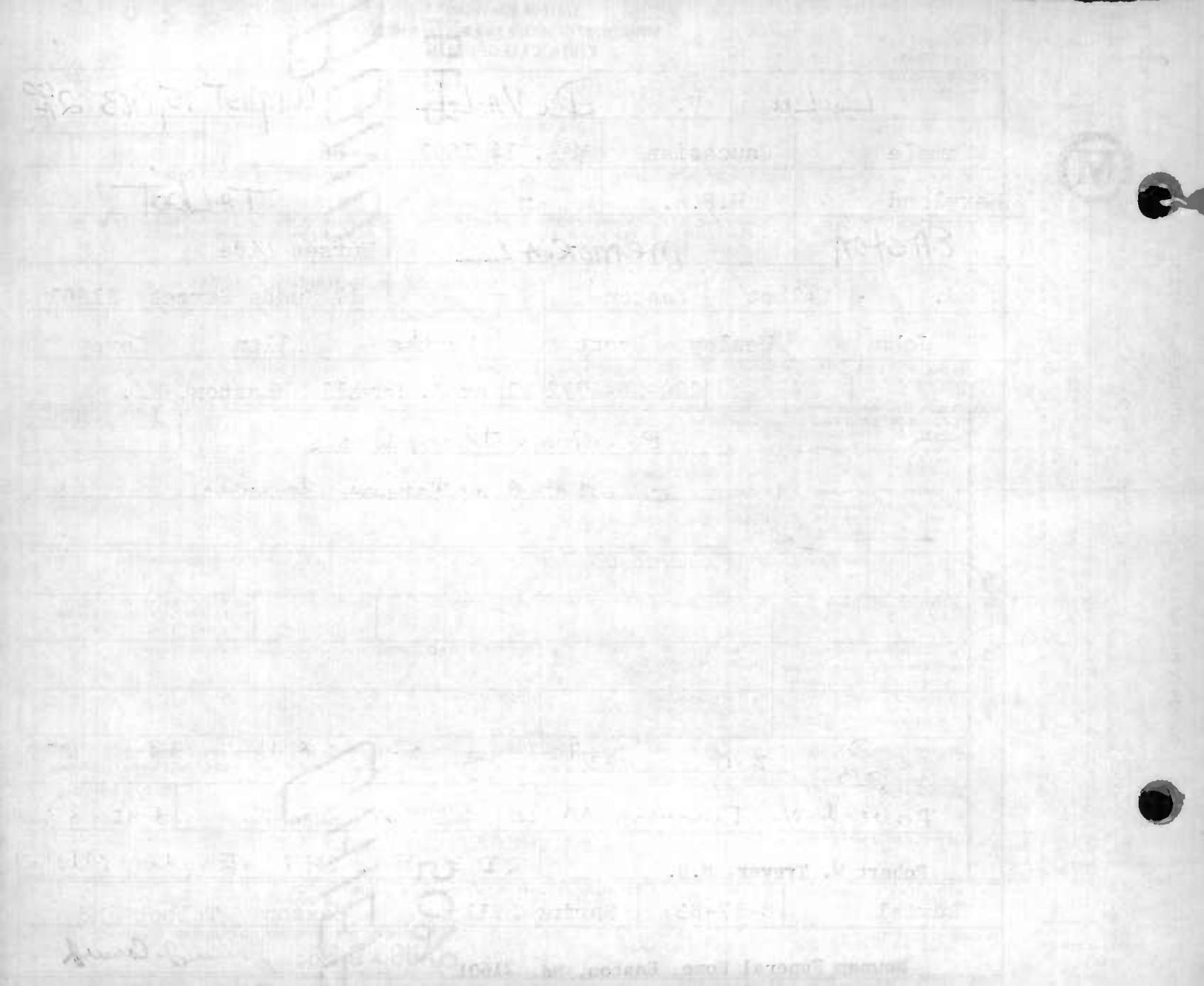
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22026

1. DECEASED NAME (TYPE OR PRINT)			FIRST LuLu	MIDDLE V.	LAST DuVALL	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR August 15, 1983 2:00		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH MAR.		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurses Aide		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 17 Judas Street 21601	
14. FATHER'S NAME FIRST John		MIDDLE Wesley	LAST Dyott	15. MOTHER'S MAIDEN NAME FIRST Martha		MIDDLE Ellen	LAST Covey	ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-28-4772		17. INFORMANT Elmer J. Duvall		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 7-7, 1983, to 8-15, 1983, that (I) (we) last saw the deceased alive on 8-15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert W. Trever, M.D.		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	22c. DATE SIGNED 8-15-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Trever, M.D.		22e. ADDRESS RD 3 Box 297 Easton Md 21601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-17-83		23c. NAME OF CEMETERY OR CREMATORIUM Spring Hill		23d. LOCATION CITY OR TOWN Easton		COUNTY Talbot	STATE Md
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md. 21601		25a. DATE REC'D. BY REGISTRAR AUG 19 1983		25b. REGISTRAR'S SIGNATURE John and Conard			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

22621

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR			REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN TO ESTIMATED DEATH MONTH DAY YEAR					
Fletcher			8 18 1983 6 A.M.					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2b. HOUR 2d HOUR		
Male	Cauca.	Oct 14 12	70 yrs.			6 A.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U. S. A.				Talbot		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial Hospital @ Easton				Farmer	Farming	
13. STATE		13a. COUNTY	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	13f. ADDRESS	
Maryland		Caroline	Denton			Tuckahoe Road	21629	
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				
Fletcher		Cooper	Elben	Jennie		Patrick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
NO		200018570		Mrs. Evelyn Elben, Denton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for items 18a, 18b, and 18c) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) starting the under- lying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Obstructive Pulmonary Dis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		22c. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
ACTUAL SIGNATURE R. Lane Wroth, M. D.		23a. DATE SPECIFY 8/21/83		23b. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		23c. LOCATION CITY OR TOWN Hillsboro		
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		ADDRESS		COUNTY Caroline		
23d. BURIAL, CREMATION, REMOVAL SPECIFY		23e. DATE		23f. NAME OF CEMETERY OR CREMATORIAL		STATE Md.		
BP		Burial 8/21/83		Greenmount Cemetery				
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Randolph P. Moore		Denton, MD.		AUG 24 1983		John J. Gaier		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND 83 DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22628									
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Myra			V.			Fluhart						AUGUST 28 1983			10:20 AM						
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			Caucasian			MONTH APRIL			DAY 16			YEAR 1895			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/>			DIVORCED <input type="checkbox"/>			
Maryland			U.S.A.												9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			The Pines			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
Easton			The Meridian Nursing Center																		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Md.			Talbot			Tilghman			YES <input checked="" type="checkbox"/>			NO <input type="checkbox"/>			Wharf Road			21671			
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME									
M.			T.			Snelling						Lucy			James						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
No			220-01-0593			Fay C. Sinclair			P.O. Box 245			Tilghman, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u>												2 weeks									
4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																					
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																					
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>19/15</u> 19 <u>to 8/28</u> 1983, that (I) (we) last saw the deceased alive on <u>8/26</u> 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>Wm. Hubard Jr.</u>			22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>8/29/83</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS															
William H. Wood, Jr., M.D.						Easton, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE						
Burial			8-30-83			St. John's			Tilghman			Talbot			Md.						
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Newnam Funeral Home															<u>James S. Crisfield</u>						
BP																					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at a

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			August 6 1983			6:10 AM				
Edward R. Fountain																
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male			Black			5 26 29			54			YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md			USA						Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
EASTON			Memorial Hospital			Cook										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21601	
Md			Talbot			EASTON						P.O. Box 458				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
Eugene			Ethel			Yes			213-22-9803			Margaret			Fountain	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			(b)			ACUTE myelomonocytic Leukemia			6 mo.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2050																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF			(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE															DEGREE	
22c. DATE SIGNED															8-6-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
Lawrence Bohan, M.D.			Easton, MD 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
8/10/83			8/10/83			Vet. Cem.			New York			D.C.		Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
George Darnell			Easton, Md.			AUG 17 1983			George Darnell							

10012 on board
C. T. T. 10012 unseaworthy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22630				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Carl									Garfield			8	7	83	8:32 A	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE			Black			MARCH 27 1914			69			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
ANGE R, NC			USA			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Talbot							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Eas ton			Memorial Hospital			TRUCK DR.			TRUCKING							
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			14. THE STATE			15. INDIAN CITY LIMITS?			13c. STREET ADDRESS			ZIP CODE				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			14. THE STATE ND.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13c. STREET ADDRESS 310 PARK AVE.			ZIP CODE 21630				
16a. FATHER'S NAME FIRST			16b. MIDDLE			16c. LAST			17. MOTHER'S MAIDEN NAME			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Sim						STEWART			DENELYN A			ADDRESS 310 PK. AVE. FED.				
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			18b. (IF YES, GIVE WAR OR DATES)			18c. SOCIAL SECURITY NO.			18d. INFORMANT							
No						213-16-8730			Ida Mae Garfield							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Ca Bradycardia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN							
22a. I certify that (I) this hospital attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive and _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN							
Burial			Aug. 11, 1983			Federal Hill Cemetery			COUNTY							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Franklin Hawkins			Pine 43						AUG 17 1983							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22631				
1 - STATE REGISTRAR									REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Barbara A. Gibson						Feb. 26 1983			8	20	83	12:35 P				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian			Feb. 26 1901			82 YRS.			MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.A.						Talbot County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Easton			Easton Memorial Hospital			Nurses' Aide										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Md.			Talbot			Easton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			109 West St.			21601	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
John			Amelia													
FIRST MIDDLE LAST			FIRST MIDDLE LAST													
Benjamin Harrison			Covington													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			213-12-5163			Pauline H. Jenkins			P.O. Box 43			Days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)																
PART 1. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)										
5849			Urinary			Acute Renal Failure						Days				
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
ASCVD			Diabetes Mellitus													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <u>5/20</u> 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did not view the body after death.			8/12 19 83			8/20 19 83										
22b. SIGNATURE <u>Donald Lewers, M.D.</u>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/22/83				
22d. PHYSICIAN'S NAME, TYPE OR PRINT			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN	
Donald Lewers, M.D.			Easton, Md. 21601			Burial			8-23-83			Tilghman Methodist			Tilghman Talbot Md	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Newnam Funeral Home			ADD'L EASTON, MD. 21601			AUG 24 1983										

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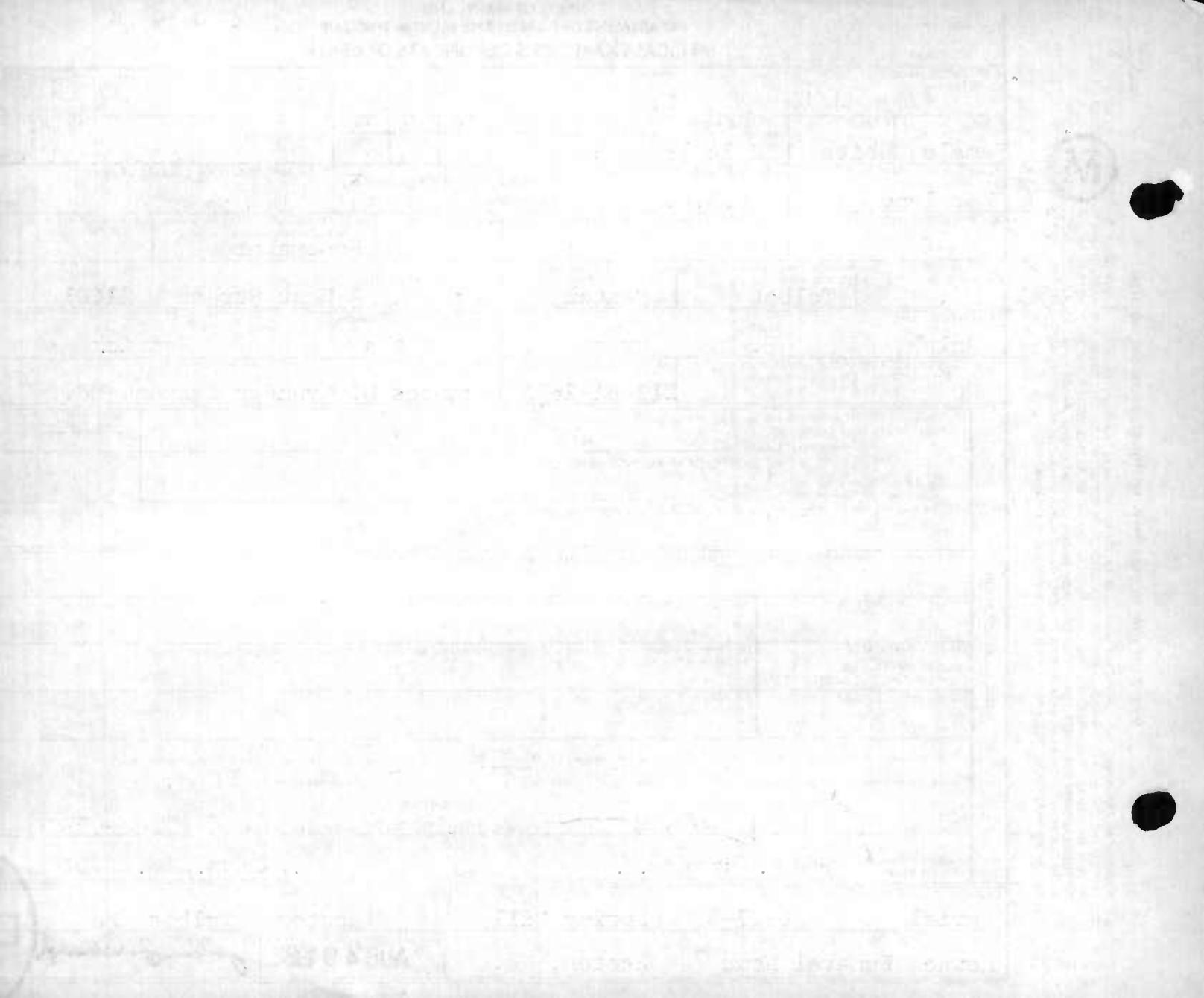
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												2 2 6 3 2					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH	DAY	YEAR	2b. HOUR
ELSIE			L.			GREEN			8		<input checked="" type="checkbox"/>	8	24	19	83		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Female		White		MAR 14 1934		49 yrs.		MONTHS		DAYS		HOURS		8 24 19 83		P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Talbot County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital										Homemaker					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Talbot		Easton		YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		8 West Street		21601					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME									
Ralph		P.		Green				Bertha		Patrick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF 7999 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO				213-84-2673		Frances M. Grunden		Easton, Md.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
												YES <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED 8-25-83					
Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE							
Burial		8-27-83		Spring Hill		Easton		Talbot		Md							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Newnam Funeral Home		Easton, Md.		AUG 29 1983		John J. Conroy											
20M 4/82																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22633	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
MARY M GREEN						8/16/83			5:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
F		B		7 24 1890			93				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
MD		USA					TALBOT CO.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
EASTON		MEMORIAL HOSPITAL								Domestic	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
MD		TALBOT		OXFORD					Tighman 21654		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			ADDRESS				
WALTER				Mary			Mildred Bailey P.O.B 281, Oxford, MD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO							1 year				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Diffuse cerebral vascular disease</u>											
4370 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) _____											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (I) (We) did not view the body after death.											
22b. SIGNATURE <u>Lawrence O'Brien MD</u> (IN PHYSICIAN'S NAME, TYPE OR PRINT)		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/20/83		23c. NAME OF CEMETERY OR CREMATORIAL Paradise			23d. LOCATION CITY OR TOWN Trappe		COUNTY STATE Talbot MD		
24. FUNERAL DIRECTOR NAME Evelyn J. Parker		ADDRESS 110 8th Street, Easton		25a. DATE REC'D. BY REGISTRAR SEP 9 1983			25b. REGISTRAR'S SIGNATURE John J. Conner				

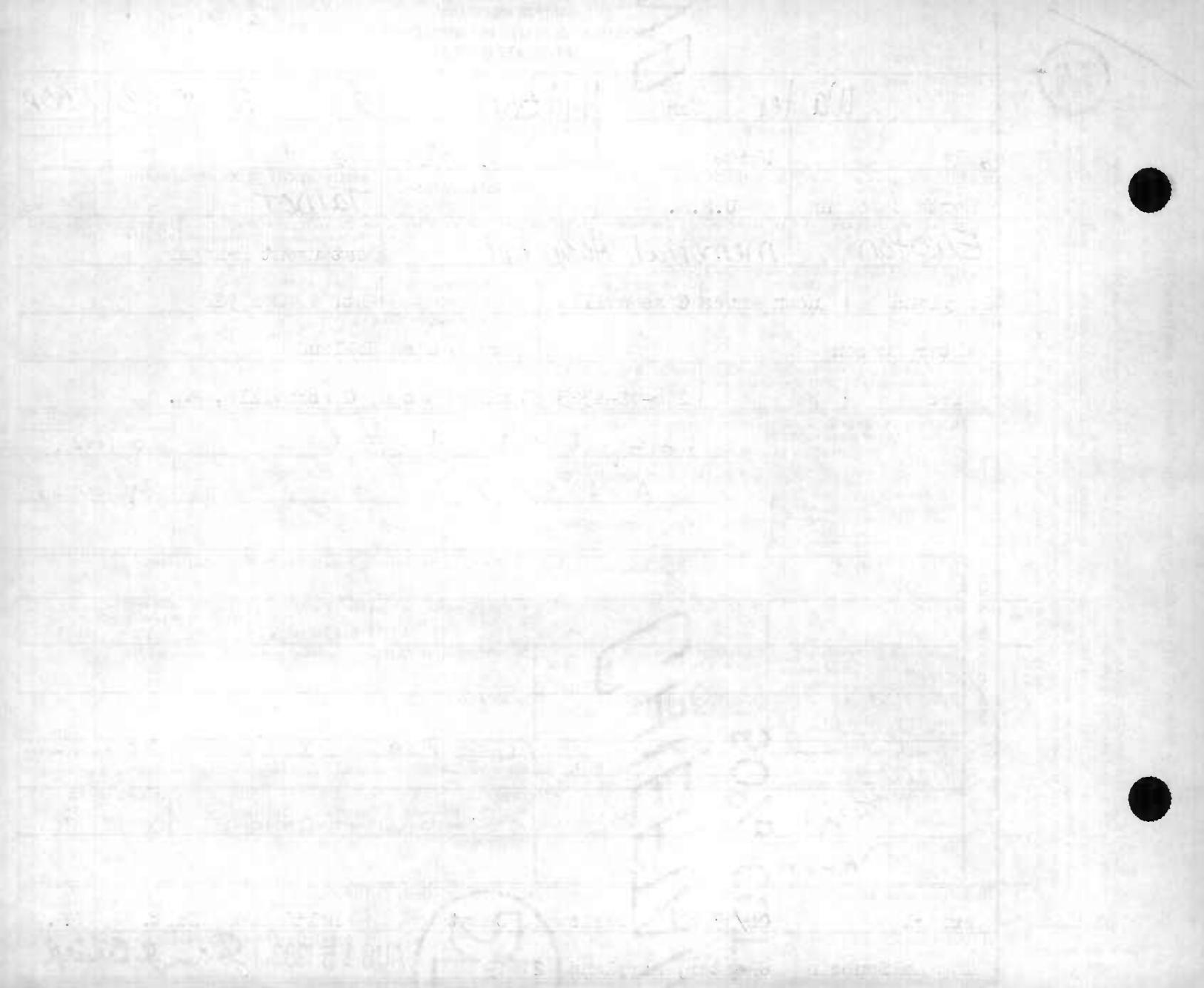
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, you should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22634		
												REG. NO.		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			8 8 10 83			1:50 P.M.		
Walter Van Hudson														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White			MONTH 01 DAY 03 YEAR 1894			89			MONTHS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			DAYS		
North Carolina			U.S.A.						Talbot			HOURS		
MD.												MIN.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Easton			Memorial Hospital			Restaurant Manager								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Queen Annes			Grasonville			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. 1 Box 528		
21638												21638		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST			FIRST MIDDLE LAST											
Walter Hudson			Anna Louise Holland											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			WW 1			218-12-4323			Louise Hudson, Grasonville, Md.			2 1/2 years		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i>														
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>A.S.C.V.D</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <i>At work</i> <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-15 1980</i> to <i>6-6 1983</i> , that (I) (we) last saw the deceased alive on <i>8-8 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Patricia S. Schley</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>8-11-83</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Al P. H. E. L. B. S. B.</i>			22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 08/13/83			23c. NAME OF CEMETERY OR CREMATORIAL Parlswood Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY Balt.		STATE MD.
24. FUNERAL DIRECTOR NAME Tom Helfenbein			ADDRESS Chester, Maryland 21619			25a. DATE REC'D. BY REGISTRAR AUG 15 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Cawley</i>					



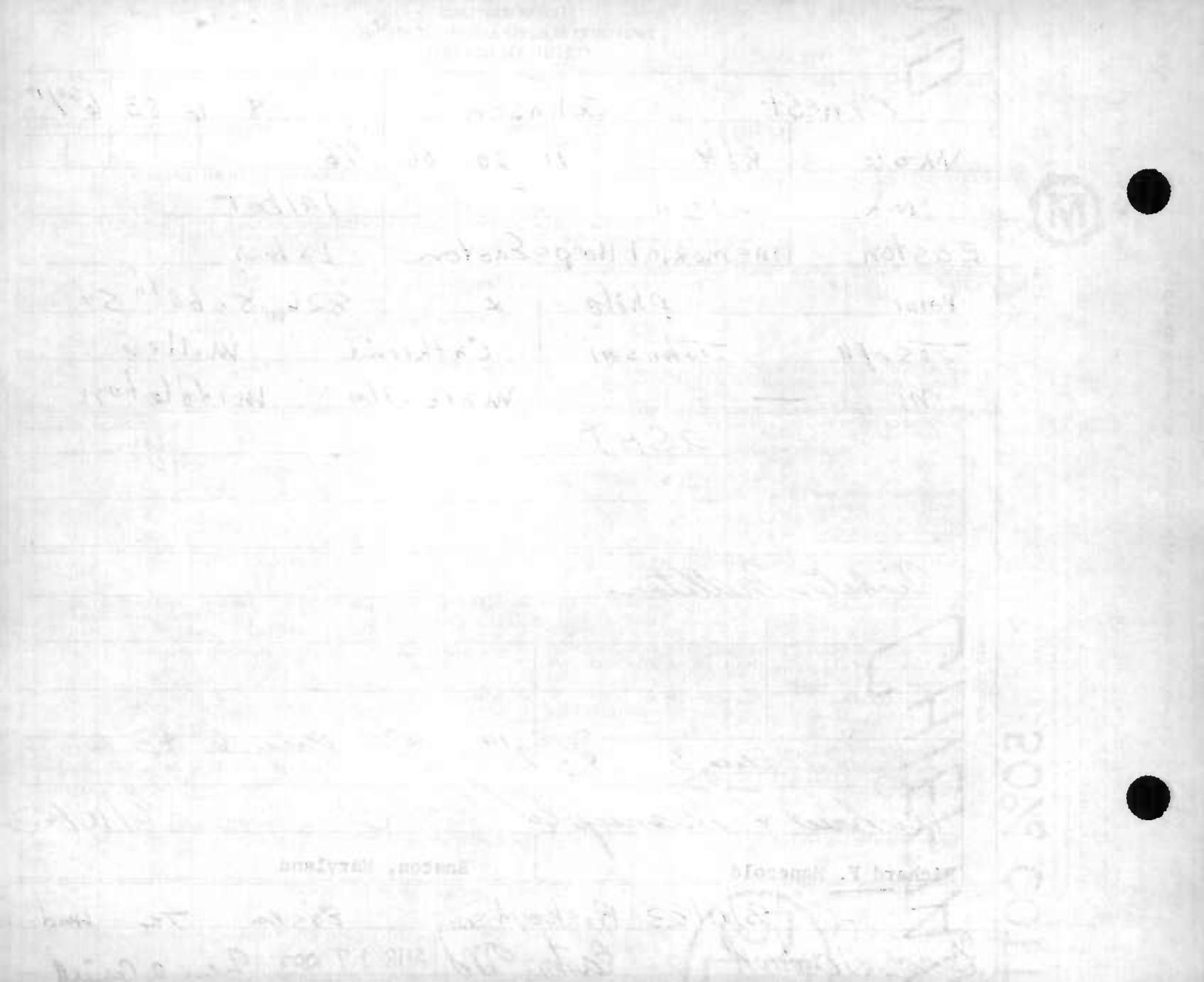
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										2263			
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ernest			Johnson			8 6 83			6 20 PM			6 20 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			B/K			MONTH 11 DAY 20 YEAR 06			76 YRS.			MONTHS DAYS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Md			USA						Talbot			MONTHS HOURS MIN.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.	
Easton			Memorial Hosp of Easton			12a. Usual Occupation Labor			12b. Kind of Business or Industry F99999				
13a. STATE Penn			13c. CITY OR TOWN Phila			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 826-5-60+954				
14. FATHER'S NAME FIRST Joseph			MIDDLE LAST Johnson			15. MOTHER'S MAIDEN NAME FIRST Catherine			MIDDLE LAST McLer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 4140			17. INFORMANT Marcello			ADDRESS middleton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>ASA.D.</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yr	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes Mellitus</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 14 1983</u> to <u>Aug 6 1983</u> , to <u>Aug 6 1983</u> , that (I) (we) last saw the deceased alive on <u>Aug 5 1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE <u>Richard F. Manegold</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/10/83							
22d. PHYSICIAN'S NAME Richard F. Manegold			22e. ADDRESS Easton, Maryland										
23a. BURIAL, CREMATION, REMOVAL ISPEC			23b. DATE 8/14/83			23c. NAME OF CEMETERY OR CREMATORIAL Richardson			23d. LOCATION CITY OR TOWN Easton COUNTY Talbot STATE Md				
24. FUNERAL DIRECTOR NAME George Daniels			ADDRESS Easton, MD			25a. DATE REC'D. BY REGISTRAR AUG 17 1983			25b. REGISTRAR'S SIGNATURE T. E. Daniels				

999999
BP

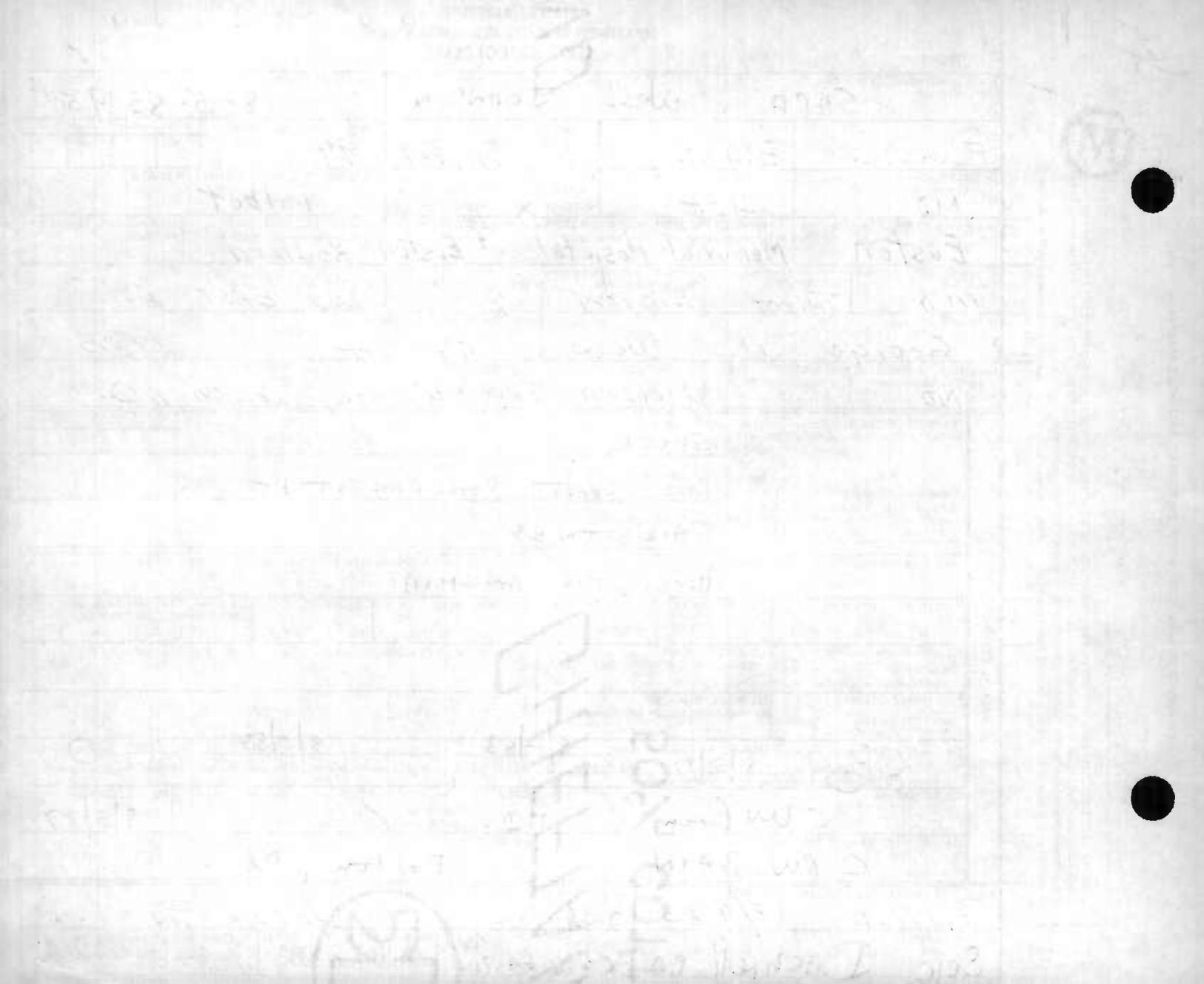


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22636					
												REG. NO.					
1 - STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			8-5-83	9:50 AM				
SARA			Webb			Johnson											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			Black			MONTH 3 DAY 14 YEAR 1884			99			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD			USA						Talbot								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial Hospital at Easton Retired														
13a. STATE MD			13b. COUNTY Talbot			13c. CITY OR TOWN EASTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 322 EAST AVE					
14. FATHER'S NAME FIRST George W.			MIDDLE Webb			LAST			15. MOTHER'S MAIDEN NAME FIRST MARTHA			MIDDLE LAST WEBB					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			Unknown			FRANCIS W. GAKS			Denton, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u>																	
5742 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>RECURRENT PANCREATITIS</u>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>GALLSTONES</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>HYPOCYTIC ANEMIA</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/4/83, 19_____ to 8/5/83, 19_____, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/5/83, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.																	
22b. SIGNATURE C. RW. BAIN			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/5/83								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. RW. BAIN			22e. ADDRESS Easton, Md.														
23a. BURIAL, CREMATION, REMOVAL (CITY)			23b. DATE 8/9/83			23c. NAME OF CEMETERY OR CREMATORIAL Richards			23d. LOCATION CITY OR TOWN EASTON			COUNTY TAL.		STATE MD.			
24. FUNERAL DIRECTOR NAME Eric Dashiell			ADDRESS P.O. BX 608 Easton						25a. DATE REC'D. BY REGISTRAR AUG 12 1983			25b. REGISTRAR'S SIGNATURE John G. Conner					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22631			
1 - STATE REGISTRAR WILLIAM HENRY JOHNSON									REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
WILLIAM HENRY JOHNSON						8 30 83					83	05 7A M			
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE			WHITE	MONTH DAY YEAR 9/26/1906			76			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
CENTREVILLE, MD.			U.S.A.						TALBOT COUNTY			MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
EASTON			EASTON MEMORIAL HOSP			SALESMAN			FOOD						
13a. STATE MARYLAND			13b. COUNTY TALBOT			13c. CITY OR TOWN EASTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 227 S. AURORA STREET 21601			
14. FATHER'S NAME FIRST CHARLES			MIDDLE JOHNSON			15. MOTHER'S MAIDEN NAME FIRST NELLIE			MIDDLE COFFEE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II A.F. 215.26.4697			17. INFORMANT HELEN E. JOHNSON			ADDRESS SAME AS 13e,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2900			DEMENTIA			DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE 'STROKES'			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(c)						5/27/83.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). PNEUMONIA.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 8/29/83, 19, to 8/30/83, 19, that (I) (we) last saw the deceased alive on 8/29/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.															
22b. SIGNATURE CRW Barn			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8-30-83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CRW Barn			22e. ADDRESS Eoston, Ruby Land												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 8/31/1983			23c. NAME OF CEMETERY OR CREMATORIAL GREEN MOUNT CREMATORIAL			23d. LOCATION CITY OR TOWN BALTIMORE			STATE MARYLAND			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 1 1983			25b. REGISTRAR'S SIGNATURE John J. Conroy						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of issue with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, strain, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22638	
												REG. NO.	
1. DECEASED NAME [TYPE OR PRINT]			FIRST Albert			MIDDLE			LAST Jones			7a. DATE OF DEATH MONTH / DAY / YEAR	8 / 9 / 83
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			7b. AGE (IN YEARS LAST BIRTHDAY) 83 yrs.			7b. HOUR 11:35 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot				
10. CITY OR TOWN OF DEATH EASTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION MEMORIAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Hardware				
13a. STATE Md.			13b. COUNTY Carloine			13c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Maple Ave. Fed., Md. 21632	
14. FATHER'S NAME FIRST Isaiah			LAST Jones			15. MOTHER'S MAIDEN NAME FIRST Lena			MIDDLE			LAST Hurlock	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDATES) 214-32-65834			17. INFORMANT Mrs. Rebecca Goslin			ADDRESS Fed., 21632 University Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Due to, or as a consequence of (b) <u>R</u> cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a atrial arrhythmia, choleystasis													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7-20, 19 87, to 8-9, 19 87, that (I) <input type="checkbox"/> last saw the deceased alive on 8-6, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input type="checkbox"/> did not view the body after death													
22b. SIGNATURE R.B. Sanchez			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/10/83				
22d. PHYSICIAN'S NAME [TYPE OR PRINT] R.B. Sanchez			22e. ADDRESS 22 Commerce Dr. Easton MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-12-83			23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery Fed.			23d. LOCATION CITY OR TOWN Caroline Md.				
23e. IN FUNERAL DIRECTOR H. Torbert Williamson			23f. DATE REC'D. BY REGISTRAR AUG 17 1983			23g. REGISTRAR'S SIGNATURE John G. Carroll							
BP _____													
DHMH - 16 50M 4/83 (VRA 15, 4)													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22639				
												REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH									MONTH	DAY	YEAR	2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)			FIRST Felix			MIDDLE Anthony			LAST KELKOWSKI Kelkowsky			8 - 1 - 83			7:25 PM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male			White			MONTH September			DAY 21			MONTH 77			YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Illinois			USA									Talbot			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN AUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION			12b. KIND OF BUSINESS OR INDUSTRY	
Easton			Memorial Hospital									Waterman Painter (Retired)			Seafood - Boat Building	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland			Queen Anne's			Queenstown			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			P.O.B. #28 Pin Tail Point Farm			21658	
14. FATHER'S NAME			FIRST Walter			MIDDLE ---			LAST Kelkowski			15. MOTHER'S MAIDEN NAME				
												FIRST Mary			LAST Rajkowski	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			R.D. #2, Box 460				
No			148-12-2884			Daughter						Mrs. Cecilia A. Morris, Queenstown, Md. 21658				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2391 Pulmonary Hemorrhage															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
(b) Probable Tumor of Lung																
(c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (the hospital) attended the deceased from Aug 1, 1983, to Aug 1, 1983, that in (my) (our) opinion death occurred on the date and hour and from the causes stated saw the deceased alive on Aug 1, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input checked="" type="checkbox"/> view the body after death.																
22b. SIGNATURE R. Rhodes MD			22c. DEGREE									ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/1/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) R. Gregg Rhodes MD			22f. ADDRESS									400 Dutchman's Lane, Easton, Md 21601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 4, 1983			23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery			23d. LOCATION CITY OR TOWN Queenstown, Q.A. Co., Md.			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Barton Funeral Home ADDRESS James H. Barton, Jr., Centreville, Md. 21617			25a. DATE REC'D. BY REGISTRAR AUG 8 1983									25b. REGISTRAR'S SIGNATURE John J. Coughlin				

2012b) und Schmidbauer (1997) zeigen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified or one of the following must be notified or one:

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22640							
										REG. NO.							
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			3. FIRST MIDDLE LAST			4. DATE OF DEATH MONTH DAY YEAR			5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 79	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.		
Oliver E Knipple									Aug 6 1982			May 15 1904	YRS.				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 79			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital					
13a. STATE Md.			13b. COUNTY Caroline			13c. CITY OR TOWN Greensboro			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Hill Road					
4. FATHER'S NAME FIRST William Knipple			5. MOTHER'S MAIDEN NAME FIRST Kathryn Ritter			6. SOCIAL SECURITY NO. 215-38-1276			17. INFORMANT Jacqueline Blunt			12b. KIND OF BUSINESS OR INDUSTRY Farming					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 215-38-1276			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 3 1983</u> to <u>Aug 6 1983</u> , that (I) (we) last saw the deceased alive on <u>Aug 3 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 8/6/83							
22c. SIGNATURE William J. Lovett MD			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS Herr Ave Denton MD 21629								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-9-83			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro			COUNTY STATE Caroline Md.					
24. FUNERAL DIRECTOR NAME John E. Boulaia			ADDRESS Greensboro, Md.			25a. DATE REC'D. BY REGISTRAR AUG 10 1983			25b. REGISTRAR'S SIGNATURE John E. Boulaia								

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Section 2: Income

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Библиография

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2264

1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Albert C Miller						8	14	83	100 p M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		JAN 9 1899		84		MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Pennsylvania		U.S.A.				TALBOT					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital				Land Surveyor					
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Trappe		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9 School Street 21673			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Norman				Miller		Ella				Saulsbury	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		218-05-8292		Marie L. Miller		Trappe, Md.		yrs.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Obstructive Lung Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Bronchitis</u> 5163											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rheumatoid Arthritis</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 12</u> , 19 <u>82</u> , to <u>Aug 14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>Aug 13</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) (had) (had not) the ability after death.											
22b. SIGNATURE <u>Richard V. Manegold</u>		22c. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Richard Manegold, M.D.		Easton, Md. 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		Anne			
Burial		8-17-83		Glen Haven Mem. Park		Glen Burnie Arundel Md		COUNTY STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md. 21601				AUG 19 1983		<u>John J. Conick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner should be notified.

BP

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1000 100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22642					
										REG. NO.					
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)							3. DATE OF DEATH MONTH DAY YEAR					
			First			MIDDLE		LAST		MONTH		DAY	YEAR	7b. HOUR 28 89 M	
4. SEX			5. RACE			6. DATE OF BIRTH MONTH DAY YEAR		7. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 12 HRS.			
M			B/K			8 15 11		72		MONTHS DAYS		HOURS MIN.			
8. BIRTHPLACE COUNTRY			9. CITIZEN OF WHAT COUNTRY?			10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SAME FACILITY, GIVE STREET ADDRESS)		12. BALTIMORE CITY OR COUNTY OF DEATH Talbot					
N.C.			USA					13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		13b. KIND OF BUSINESS OR INDUSTRY water man					
14. CITY OR TOWN OF DEATH Eason			15. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Memorial Hospital			16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS Box 75 21662							
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			19. STATE Md			20. COUNTY Talbot		21. CITY OR TOWN Bellevue		22. STREET ADDRESS Box 75 21662					
23. FATHER'S NAME First			24. MOTHER'S NAME M			25. MOTHER'S MAIDEN NAME K						LAST			
26. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>			27. SOCIAL SECURITY NO. 4149 217-07-4447			28. INFORMANT Movie		29. ADDRESS Moore				30. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
31. CAUSE OF DEATH (Enter only one cause per line. Do not list, and so.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. b) DUE TO, OR AS A CONSEQUENCE OF c)															
32. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b.															
33a. DATE OF OPERATION			33b. CONDITION FOR WHICH OPERATION WAS PERFORMED							33c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		33d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
34a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			34b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			34c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 3b, PART 1 OR PART 3)									
35a. INJURY OCCURRED			35b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			35c. LOCATION STREET		35d. CITY OR TOWN		35e. COUNTY		35f. STATE			
36a. I certify that (1) this hospital attended the deceased from saw the deceased alive on 19 83 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I have) <input type="checkbox"/> and did not view the body after death.			36b. DATE OF INJURY 20 Aug 1983			36c. 19 97 to 24 Aug 1983		36d. CITY OR TOWN Eason		36e. COUNTY Talbot		36f. STATE Md			
37a. SIGNATURE Lynn Whittle, MD			37b. DEGREE MD			37c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		37d. DATE SIGNED 8-26-83							
38a. PHYSICIAN'S NAME (TYPE OR PRINT)			38b. ADDRESS												
39a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			39b. DATE 8/27/83			39c. NAME OF CEMETERY OR CREMATORIAL Eason			39d. LOCATION CITY OR TOWN Eason		39e. COUNTY Talbot		39f. STATE Md		
40a. FUNERAL DIRECTOR NAME George Dashill			40b. ADDRESS Eason Md.			40c. DATE REC'D. BY REGISTRAR SEP 6 1983			40d. REGISTRAR'S SIGNATURE John G. Conner						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please & may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8-3 22643		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Ivan Richard Morrin			AUGUST 29, 1983				M
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		
Male		Caucasian	AUG 9 1924		59 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania		U.S.A.			Talbot MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Easton		15 Plum Street			Minister		
13a. STATE Md.		13b. COUNTY Talbot	13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15 Plum St. 21601
14. FATHER'S NAME FIRST Hugh		MIDDLE Barton	LAST Morrin	15. MOTHER'S MAIDEN NAME FIRST Hilda		MIDDLE	LAST Erismann
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
Yes WW II		195-14-1028		L. Nell Morrin		Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2030 MULTIPLE MYELOMA APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF 6 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 8-29 1983 to 8-29 1983, that (I) (was not saw the deceased alive on 8-22 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen P. Carney, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-31-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen P. Carney, M.D.		22e. ADDRESS Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-1-83		23c. NAME OF CEMETERY OR CREMATORIAL Zion Church Cemetery		23d. LOCATION CITY OR TOWN Millersville Lancaster STATE PA	
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.		25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE SEP 2 1983 John J. Carney			

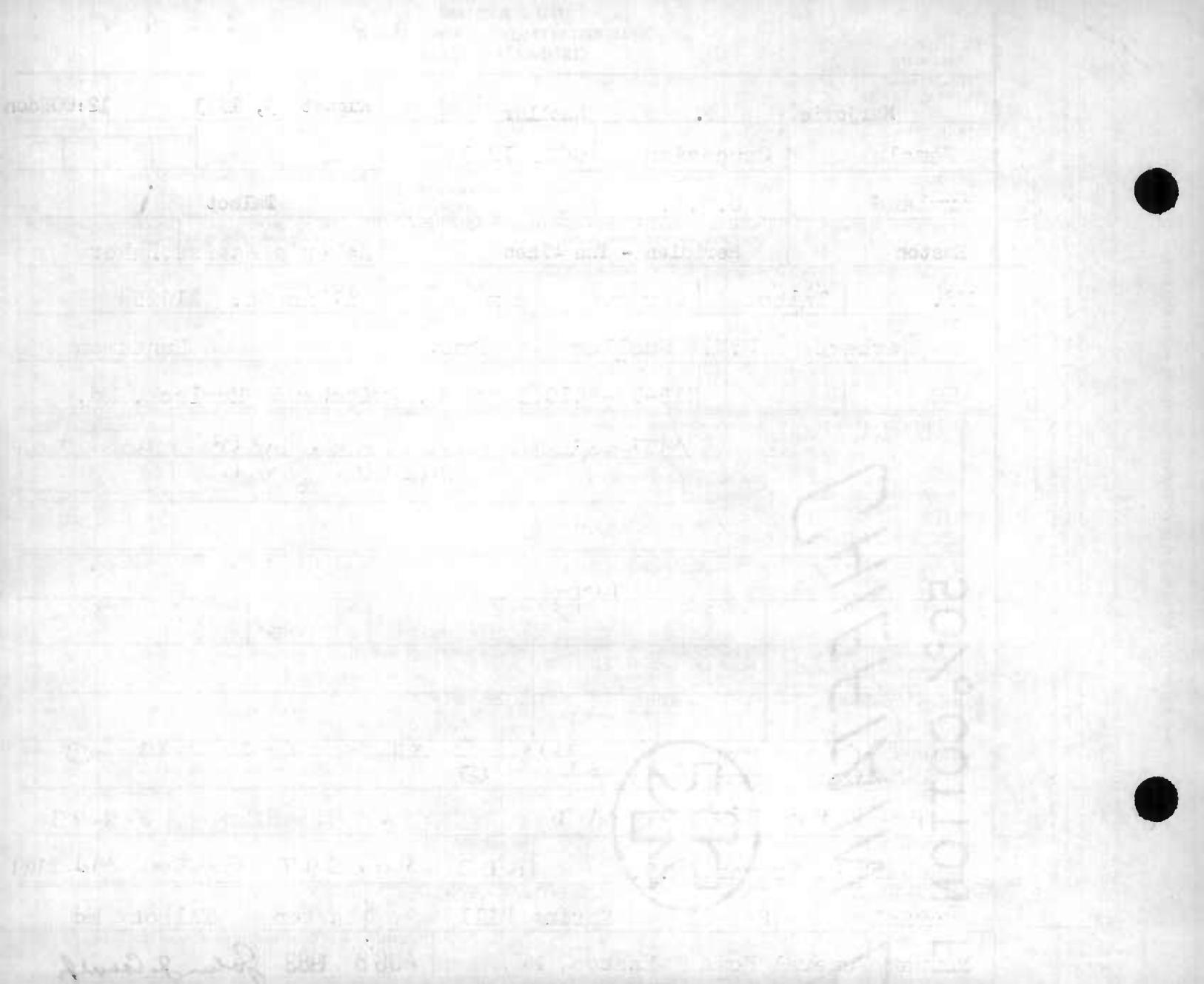


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

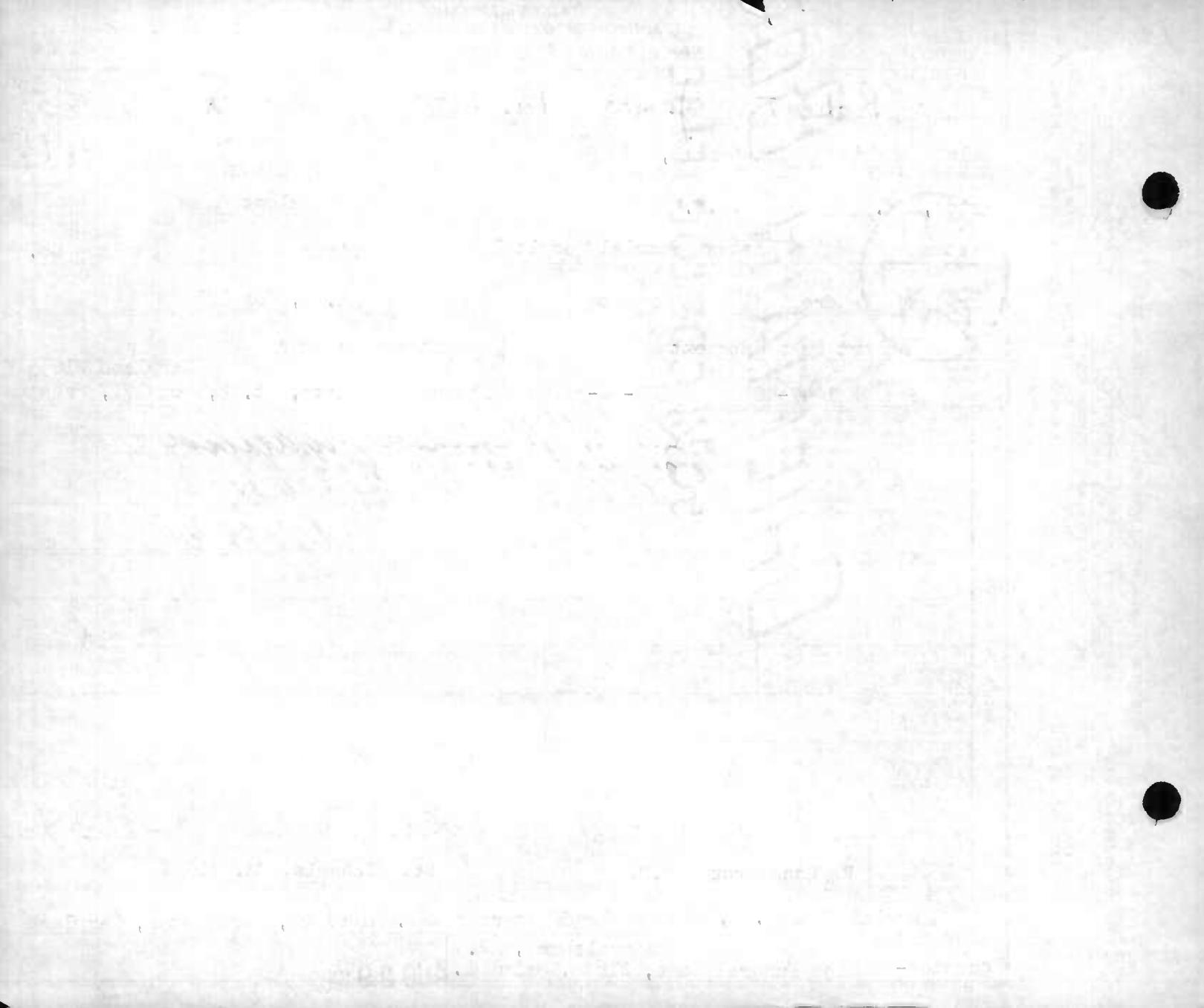
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22644								
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Marjorie			F.	Mueller		August 3, 1983						12:00 noon						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		Caucasian		OCT. 12 1917		65			MONTHS		DAYS HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			MD.						
Maryland		U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Talbot												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Easton		Meridian - The Pines		Baker's Assist			Bakery											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Md.		Talbot		Cordova		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Willis St. 21625									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE			LAST				
		Herbert	W.H.	Mueller	Erna									Hunteman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS											
NO		213-70-8010		Betty M. Pritchard			Hurlock, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of the ampulla of Vater</i>										<i>uncertain</i>								
1562 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic carcinoma of the ampulla of Vater</i>																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
None																		
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)														
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that (I) this hospital) attended the deceased from <i>3-18</i> , 19 <i>83</i> , to <i>8-3</i> , 19 <i>83</i> , that (I) we last saw the deceased alive on <i>8-3</i> , 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.																		
22b. SIGNATURE <i>Robert W. Trever, M.D.</i>										DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED <i>8-3-83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert W. Trever, M.D.</i>										22e. ADDRESS <i>RD 3 Box 297 Easton, Md. 2161</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE					
Burial		8-5-83		Spring Hill			Easton			Talbot			Md.					
24. FUNERAL DIRECTOR NAME <i>Newnam Funeral Home</i>										ADDRESS <i>Easton, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 8 1983</i>					
													25b. REGISTRAR'S SIGNATURE <i>John C. Cawie</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B (GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR). PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22645	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR	
Robert James Patchett						8 21 1983			5 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		9c. DATE PRONOUNCED DEAD	
Male		White		October 13, 1928		54 yrs.						8 21 1983	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11b. CITIZEN OF WHAT COUNTRY?		12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Rt. 2, Box 171	
Easton, Md.		U.S.A.		Easton Memorial Hospital		Maryland		Caroline		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21655	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS		20b. KIND OF BUSINESS OR INDUSTRY Poultry Co.	
Robert Duke Patchett		Gertrude Seymour		1947-48		Blanche Patchett, Rt. 2, Box 171, Preston		203-24-3770		Maryland 21655			
18. CAUSE OF DEATH (Enter only one cause per line for Part 1a) (1a) DUE TO (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF (d) DUE TO, OR AS A CONSEQUENCE OF													
PART 1 DEATH WAS CAUSED BY 4100 IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a) starting the underlying cause last: Gastroenteritis, Nausea, Vomiting, Diarrhea Gastritis, Ulcer, Nausea, Vomiting Gastritis, Ulcer, Diarrhea, Nausea, Vomiting Gastritis, Ulcer, Diarrhea, Nausea, Vomiting													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. Lane Wroth, M.D.			Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			and in my opinion							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 24, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Maryland Veterans Cem.			23d. LOCATION CITY OR TOWN Hurlock, Dorchester, Maryland				
24. FUNERAL DIRECTOR NAME Frampton-Hawkins Funeral Home, 216 N. Main St.			ADDRESS Federalsburg, Md.			25a. DATE REC'D. BY REGISTRAR AUG 29 1983			25b. REGISTRAR'S SIGNATURE J. Lane & Company				



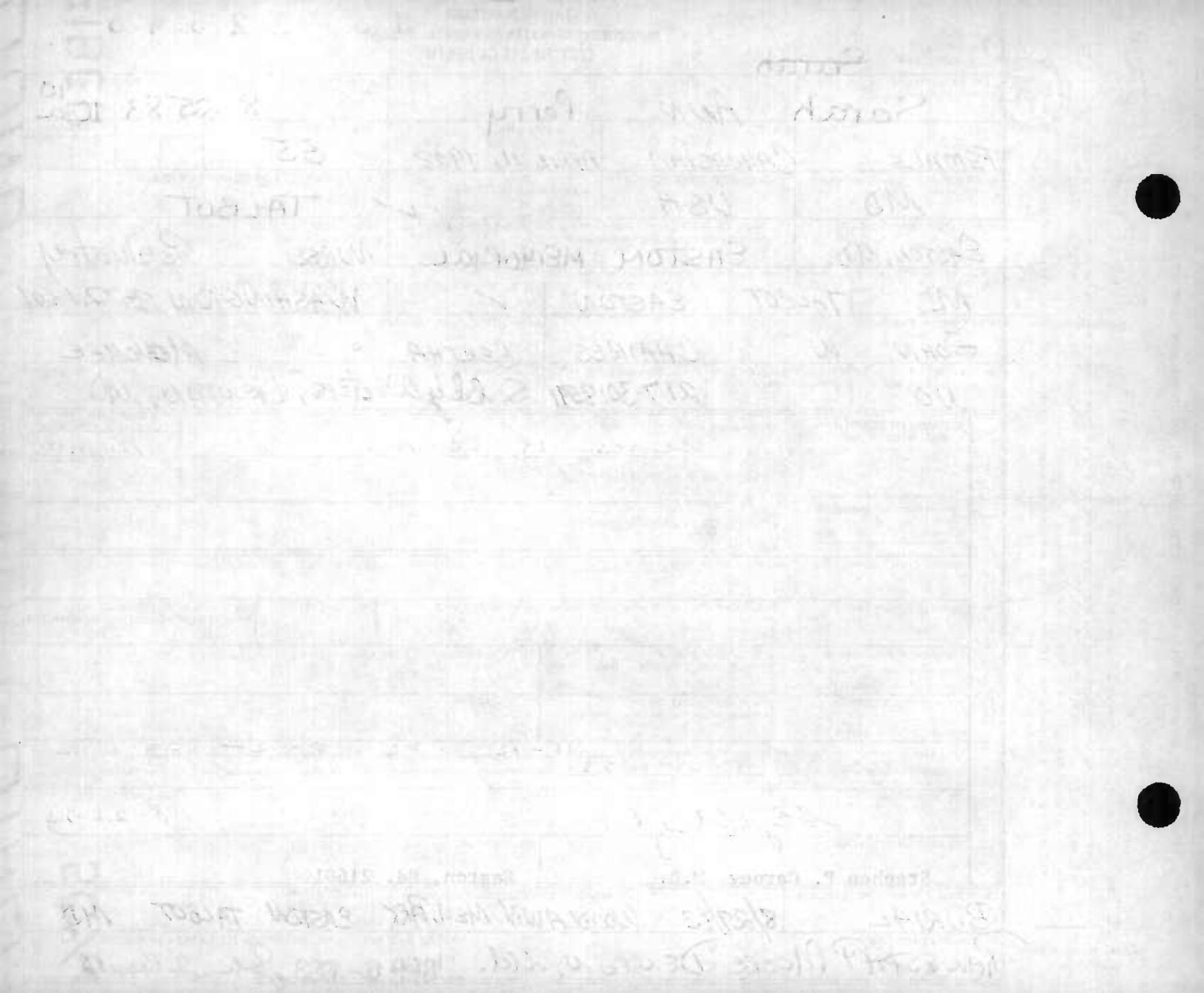
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 22646
1 - FOR STATE REGISTRAR		Sarah			
2a. DECEASED NAME (TYPE OR PRINT)		FIRST Sarah	MIDDLE Ann	LAST Perry	2a. DATE OF DEATH MONTH DAY YEAR 8 25 83
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH APRIL DAY 11 YEAR 1928	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR 55 YRS. MONTHS DAYS HOURS 10 10am
7a. BIRTHPLACE COUNTRY MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT
10. CITY OR TOWN OF DEATH EASTON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE 12b. KIND OF BUSINESS OR INDUSTRY Psychiatry
13a. STATE MD		13b. COUNTY TALBOT	13c. CITY OR TOWN EASTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET, ADDRESS ZIP CODE WASHINGTON ST. 21601
14. FATHER'S NAME FIRST JOHN		MIDDLE W	LAST CHAIR	15. MOTHER'S MAIDEN NAME FIRST BERTHA	MIDDLE LAST McNamee
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-30-8591		17. INFORMANT Sally Wooters, DENTON, MD	ADDRESS 10 mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of colon</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>82</u> , to <u>8-25</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>8-25</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stephen P. Carney, M.D.		DEGREE		22c. DATE SIGNED 8-26-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		23b. DATE 8/27/83	23c. NAME OF CEMETERY OR CREMATORIAL WOODLAWN MEM. PARK	23d. LOCATION CITY OR TOWN EASTON TALBOT MD	23e. DATE
24. FUNERAL DIRECTOR NAME JOSEPH P. MOORE		ADDRESS DENTON, MD.		25a. DATE REC'D. BY REGISTRAR SEP. 6-1983	25b. REGISTRAR'S SIGNATURE John J. Carney

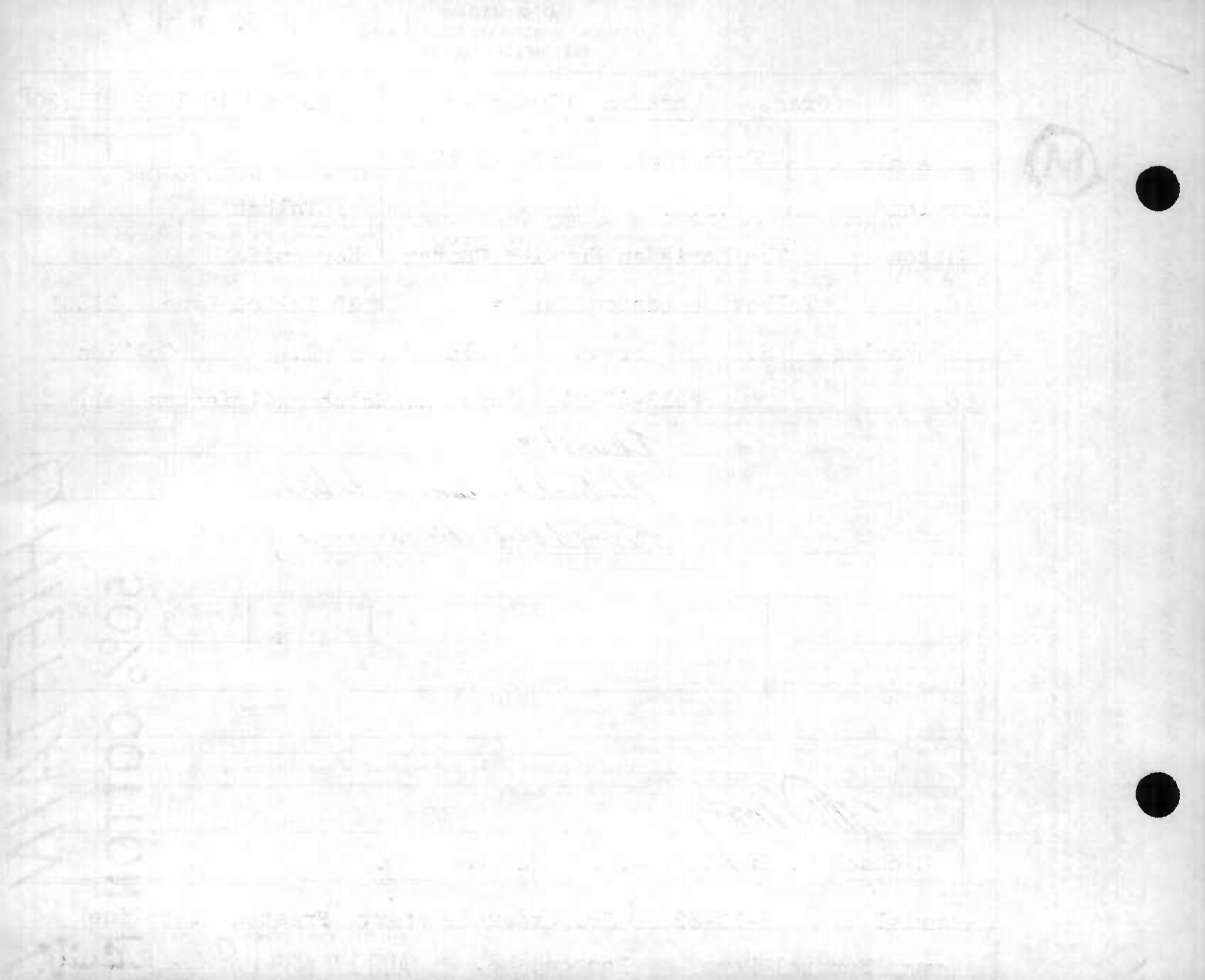


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22641	
												REG. NO.	
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Grace Martina Plutschak						AUGUST 10 1983			11:30 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Female			Caucasian			APRIL 25 1903			80 YRS.			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Maryland			U.S.A.						Talbot			Easton	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY	
The Meridian Nursing Center			THE PINES			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20 Talbot Lane 21601			Housewife	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			15. MOTHER'S MAIDEN NAME			14. FATHER'S NAME	
Md.			Talbot			Easton			Leila			Charles H. Bryan	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			213-42-0424			Joyce A. Walsh			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Wilmington Del.	
									1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Transiton	
									DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic cancer to brain				
									DUE TO, OR AS A CONSEQUENCE OF (c) Transitional cell carcinoma of bladder				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Michael D. Crowley, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael D. Crowley, M.D.			22e. ADDRESS Easton, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-13-83			23c. NAME OF CEMETERY OR CREMATORIAL Jr. Order Cemetery			23d. LOCATION CITY OR TOWN Preston Caroline Md COUNTY STATE				
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR AUG 17 1983			25b. REGISTRAR'S SIGNATURE John D. Crowley				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove, or removal, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22048				
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Ham			Presley			8 11 83			4:05 A.M.					
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 12 27 03			6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot					
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Gen. Delivery			12b. KIND OF BUSINESS OR INDUSTRY 21632					
13a. STATE Md.			13b. COUNTY Caroline			13c. CITY OR TOWN Federalsburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Peach		
14. FATHER'S NAME FIRST Joel			MIDDLE LAST Presley			15. MOTHER'S MAIDEN NAME Frances								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. Unkn. 263-07-6575			17. INFORMANT			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) OR (c). PART 1. DEATH WAS CAUSED BY: 5713 IMMEDIATE CAUSE (a) <u>Hepatic failure</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic liver disease</u> (c) _____													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Aug 10 1983			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from Aug 5 1983 to Aug 11 1983, that (1) (we) lost saw the deceased alive on Aug 10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) saw the body after death.													22c. DATE SIGNED 8/11/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
Richard Manegold, M.D.						Easton, Md. 21601								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 8/15/83			23c. NAME OF CEMETERY OR CREMATORIAL Balto., Md.			23d. LOCATION CITY OR TOWN 1			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Anatomy Board			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 18 1983			25b. REGISTRAR'S SIGNATURE James J. Conroy					

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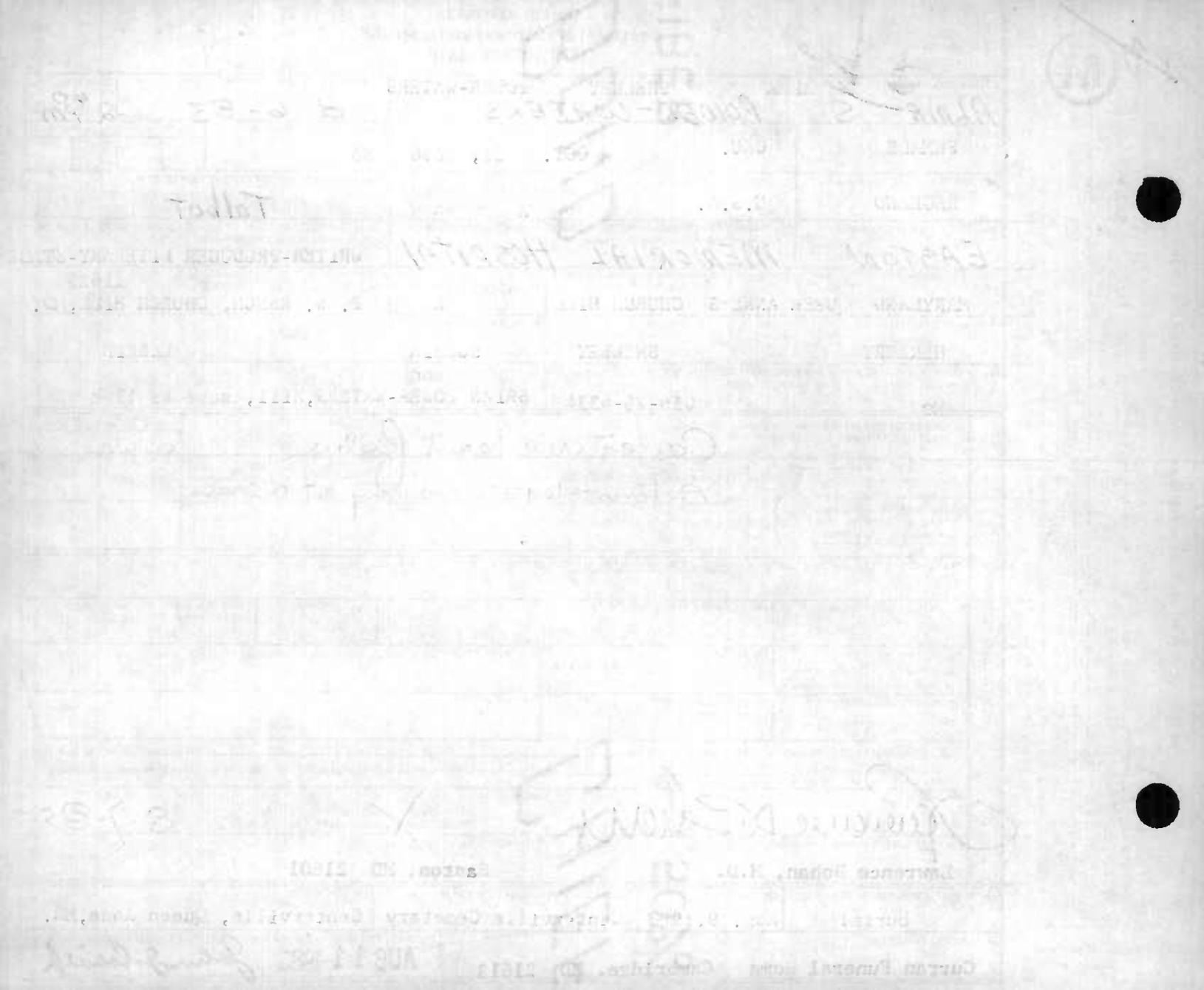
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SERIALS SECTION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the date shown in Item 1.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22649					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ALMA S POWER-WATERS										2a. DATE OF DEATH 8-6-83	MONTH DAY YEAR	2b. HOUR 2:40 PM			
3. SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH OCT. 21, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot		10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WRITER-PRODUCER		12b. KIND OF BUSINESS OR INDUSTRY LITERARY-STAGE	
13a. STATE MARYLAND		13b. COUNTY QUEEN ANNE'S		13c. CITY OR TOWN CHURCH HILL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. W. RANCH, CHURCH HILL, MD. 21623							
14. FATHER'S NAME FIRST HERBERT		MIDDLE LAST SHELLEY		15. MOTHER'S MAIDEN NAME FIRST SOPHIA		MIDDLE LAST LARKIN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 056-24-4334		17. INFORMANT SON		ADDRESS BRIAN POWER-WATERS, XIII, same as 13 e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY															
IMMEDIATE CAUSE (a) Congestive heart failure APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks															
4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary art disease															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c)															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. DATE SIGNED 8-7-85															
22c. MEDICAL SIGNATURE Dr. Lawrence Bohan, M.D.															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence Bohan, M.D.		22e. ADDRESS Easton, MD 21601													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE Aug. 9, 1983		23c. NAME OF CEMETERY OR CREMATORIUM Centerville Cemetery		23d. LOCATION CITY OR TOWN Centerville, Queen Anne, Md.		23e. COUNTY Queen Anne, Md.		23f. STATE MD					
24. FUNERAL DIRECTOR NAME Curran Funeral Home		ADDRESS Cambridge, MD 21613		25a. DATE REC'D. BY REGISTRAR AUG 11 1983		25b. REGISTRAR'S SIGNATURE John J. Curran									



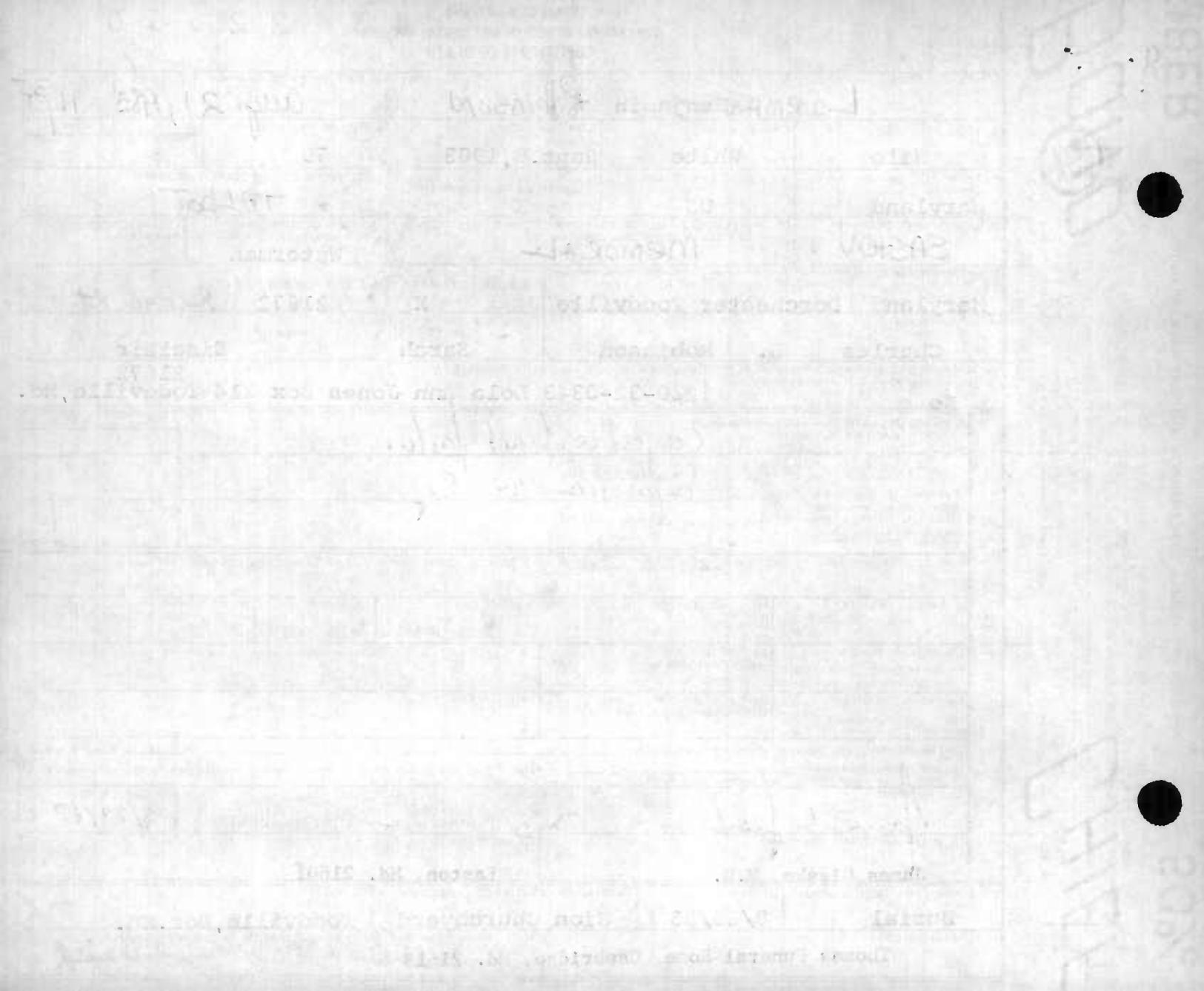
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Page 1 and 2 should be detached for use as the burial/transit permit. Then please return carbon paper, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or otherwise.

IMPORTANT: If item 21 is marked or item 19 shows any injury or other findings in addition to the medical examiner's report, the medical examiner's report must be initialed at item 21.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22650									
										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR										
LURMAN Benjamin Robinson						Aug. 21 1983			11 35										
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR									
Male		White		Sept. 8, 1903			79			MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Maryland		US					TALBOT			Waterman			MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH CITY, GIVE STREET ADDRESS)								12a. STREET ADDRESS / ZIP CODE									
EASTON		Memorial								21672 RURAL RT.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE									
Maryland		Dorchester		Toddville						21672									
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Charles		L. Robinson			Sarah			220-32-0343			Lola Ann Jones Box 214 Toddville, Md.			21672					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR ORDAIES)			16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
No																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>																			
4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Infarction (R) leg</u>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE								
21f. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>																			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED 8/22/83				
22b. SIGNATURE <u>James Gieske</u>															22d. DEGREE <u>MD</u>				
22e. ADDRESS James Gieske, M.D. Easton, Md. 21601															22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE									
Burial		8/25/83		Zion Churchyard			Toddville, Dor. Md.												
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE																	
Thomas Funeral Home		AUG 9 1983																	
		John J. Conigli																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 - FOR STATE REGISTRAR											REG. NO. 2205		
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR 8-25-83			2b. HOUR 6 AM	
John W. Rogers													
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR AUG 9 1905			6. AGE (IN YEARS LAST BIRTHDAY) 78 yrs			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Talbot Co.			MD.	
10. CITY OR TOWN OF DEATH Easton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) EASTON MEMORIAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Service			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Talbot			13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Rt. 3, Box 185 21601	
14. FATHER'S NAME FIRST George			MIDDLE			LAST Rogers, Sr.			15. MOTHER'S MAIDEN NAME FIRST Rebecca			MIDDLE	LAST Wilmer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 219-16-0666			17. INFORMANT Mary Ann Rogers Easton, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest 1991 DUE TO, OR AS A CONSEQUENCE OF (b) hyperthermia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) the basal metastases (prostatic) in widespread metastases												PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Ascd - coronary artery disease - Parkinson's disease	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that (I) (this hospital) attended the deceased from 3/14/83 to 8/25/83, that (I) (we) lost the deceased alive on 9/24/83, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/20/83				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALBERT T. DAWKINS JR.			22e. ADDRESS Route 3, Box 127			22f. ADDRESS			22g. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-25-83			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes			23e. COUNTY SUSSEX	23f. STATE DEL.
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR AUG 29 1983			25b. REGISTRAR'S SIGNATURE John G. Smith				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, unless furnished by the hospital or attending physician.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22653
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED			2b. HOUR M. H. M.			
James			Cooper	Cooper	Saulsbury	1981 19 83 500 PM			1983 9 2 19 45 PM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	9. DATE PRONOUNCED DEAD			10. DATE OF DEATH MONTH DAY YEAR	11. HOUR M. H. M.		
Male	White	JUNE 5 1911	72 yrs.			9. DATE PRONOUNCED DEAD			9 2 19 83 9 PM	11. HOUR M. H. M.		
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		13. CITIZEN OF WHAT COUNTRY?			14. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			15. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.						Talbot				
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF AGED IN SUCH FACILITY, GIVE STREET ADDRESS)			18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			19. KIND OF BUSINESS OR INDUSTRY				
Trappe		R.D. 1, Box 144 Windy Hill			Farmer							
20. STATE		21b. COUNTY		21c. CITY OR TOWN		21d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21e. STREET ADDRESS				
Md.		Talbot		Trappe		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 1, Box 144		21673		
22. FATHER'S NAME FIRST		MIDDLE		LAST		23. MOTHER'S MAIDEN NAME FIRST		24. ADDRESS				
James				Saulsbury, Sr.		Carrie		Cooper				
25a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATE)		25b. SOCIAL SECURITY NO.		25c. INFORMANT		25d. ADDRESS						
Yes		WW II		555-34-8123		Nancy S. Tappan		Springfield, VA.				
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 4149 IMMEDIATE CAUSE(s) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
27. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a), b), and (c).												
28a. DATE OF OPERATION			28b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						28c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
29a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 28 PART 1 OR PART 2)						
30a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			30c. LOCATION STREET			30d. CITY OR TOWN			
31a. I CERTIFY THAT I TOOK CHARGE OF THE REMAINS DESCRIBED ABOVE, HELD ON DEATH RESULTED FROM: NATURAL CAUSES <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED MANNER <input type="checkbox"/> ACTUAL SIGNATURE R. Lane Wroth, M.D.			31b. MEDICAL EXAMINER			31c. INQUIRY <input checked="" type="checkbox"/> AND IN MY OPINION						
32a. EXAMINER'S NAME (TYPE OR PRINT)			32b. ADDRESS			32c. DATE SIGNED			32d. DATE			
R. Lane Wroth, M.D.			St. Michaels, Md. 21663			8-3-83						
33a. BURIAL, CREMATION, REMOVAL (SPECIFY)			33b. NAME OF CEMETERY OR CREMATORIAL			33c. LOCATION CITY OR TOWN			33d. COUNTY			
Cremation			Delmarva Crematory			Lewes			Sussex			
34. FUNERAL DIRECTOR NAME			ADDRESS			35a. DATE RECD. BY REGISTRAR			35b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home			Easton, Md. 21601			AUG 6 1983			John J. Conner			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical certifying physician should be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22654
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>Esther</u>	MIDDLE <u>Malcolm</u>	LAST <u>SHANKS</u>	2a. DATE OF DEATH			MONTH 8	DAY 24	YEAR 83	2b. HOUR 9:30 AM
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH June			DAY 25	YEAR 1915	6. AGE (IN YEARS LAST BIRTHDAY) 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New Jersey</u>			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>TALBOT</u>			
10. CITY OR TOWN OF DEATH <u>EASTON</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>MEMORIAL Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wife			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE <u>Maryland</u>			13b. COUNTY <u>QueenAnne's</u>	13c. CITY OR TOWN <u>Grasonville</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 214 <u>Maryland Route 18, 21638</u>		
14. FATHER'S NAME FIRST <u>Arthur</u>			MIDDLE <u>Edward</u>	LAST <u>Ferren</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Ruth</u>			MIDDLE <u>Irene</u>	LAST <u>Gaunt</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>147-12-0605</u>			17. INFORMANT Husband <u>George F. Shanks, Sr., Grasonville, Md. 21638</u>			ADDRESS P.O. Box 214			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —
1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastases to Lung</u> (c) <u>Pleura, Liver</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ASHD</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>D. Rhodes</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/24/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P. Gregg Rhodes MD</u>			22e. ADDRESS <u>400 Dutchman's Lane, Easton, Md</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 27, 1983			23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield			23d. LOCATION CITY OR TOWN Centreville, Q.A.C.O., Md.			
24. FUNERAL DIRECTOR NAME Barton Funeral Home James H. Barton, Jr., Centreville, Md. 21617						25a. DATE REC'D. BY REGISTRAR AUG 31 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed within 24 hours after death should be filed with the State Dept. of Health and Mental Hygiene or a burial cremation or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22655

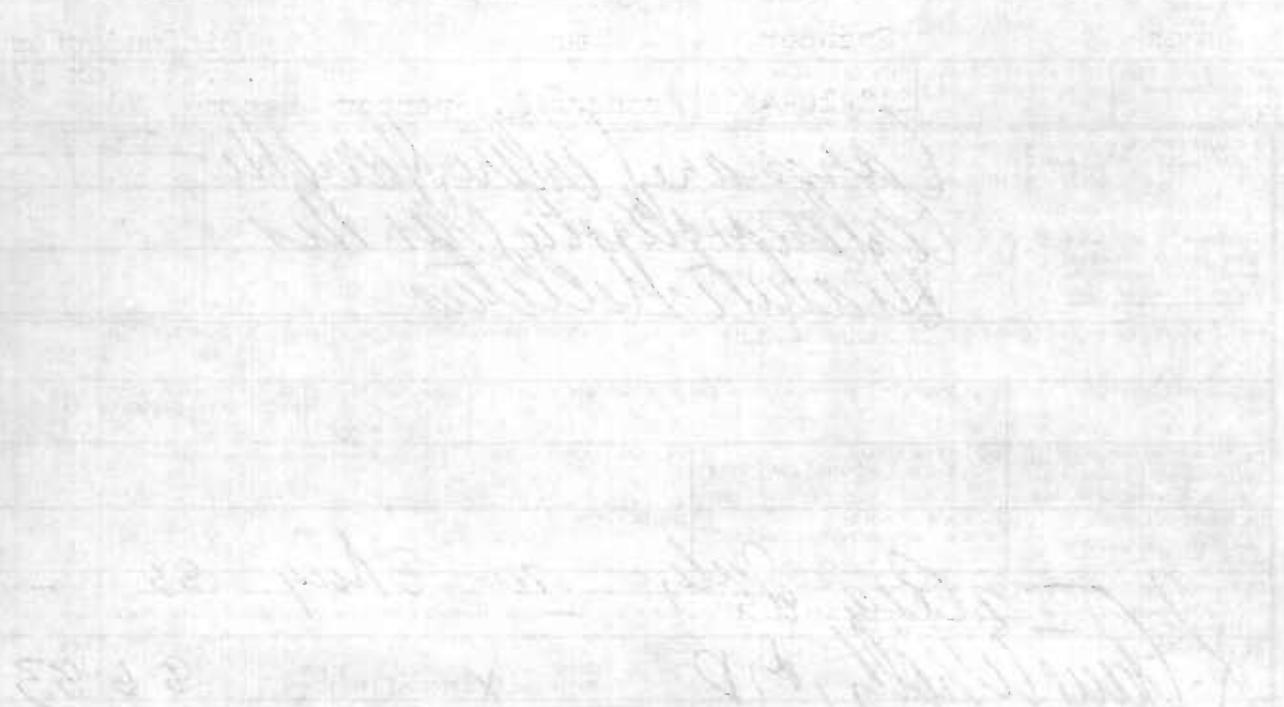
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			
James A. Spencer						8-5-83			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Male		Caucasian		DEC. 24 1901		81 yrs.		8 PM	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Talbot			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial		Mechanic		\$ewing Machine			
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. STREET ADDRESS			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Md	Talbot	Easton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 4, Box 372 21601				
14. FATHER'S NAME			15. MOTHER'S MARRIED NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
FIRST James	MIDDLE	LAST Spencer	FIRST Emma			LAST Diefenderfer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		212-10-4584		Frances A. Spencer		R.D. 4, Box 372 Easton, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2500									
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)									
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 20, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>									
22a. I certify that (I) (the physician) attended the deceased from July 19 83 to Aug 19 83, that (I) (we) lost saw the deceased alive on 19 83 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above at (we) (I) (we) (we) (we) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
R. Lane Wroth, M.D.						8-6-83			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
Burial		8-9-83		Spring Hill		Easton		Talbot Md	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md.		AUG 10 1983		John J. Cawley			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the certificate returned to the hospital or attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22056

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
HOWARD J STANT						8	1	83		1:20 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		MONTH 11	DAY 24	YEAR 1893	89	YRS.	MONTHS	MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.		
EASTON.		MEMORIAL HOSPITAL, EASTON.				TALBOT.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
EASTON.			MEMORIAL HOSPITAL, EASTON.			Farmer			Farming			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			21656	
Maryland			Queen Anne's		Price							
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST			
William James Stant (Deceased)						Alice Carter Stant (Deceased)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			
NO			215-38-1790			Rebecca Dean			XXXXXX, Church Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Congestive Heart Failure			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140									4 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)									
			(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 7/31/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						7/31/83			19 83	to 8/1/83	19 83	
22b. SIGNATURE Howard J			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/1/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.M. Howard			22e. ADDRESS EASTON MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 08/03/83			23c. NAME OF CEMETERY OR CREMATORIAL Church Hill Cemetery			23d. LOCATION CITY OR TOWN Church Hill		COUNTY Q.A.	STATE MD.
24. FUNERAL DIRECTOR NAME Tom Helfenbein			ADDRESS Chester, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 8 1983			25b. REGISTRAR'S SIGNATURE John J. Connealy			

REVIEWER: W. J. STANTE DATE: 7-20-68 GRADE: 10

1. What is the capital of the state of California? SACRAMENTO

2. What is the capital of the state of Texas? AUSTIN

3. What is the capital of the state of Florida? TALLAHASSEE

4. What is the capital of the state of New York? ALBANY

5. What is the capital of the state of Michigan? DETROIT

6. What is the capital of the state of Massachusetts? BOSTON

7. What is the capital of the state of Connecticut? HARTFORD

8. What is the capital of the state of Rhode Island? PROVIDENCE

9. What is the capital of the state of New Jersey? TRENTON

10. What is the capital of the state of New Hampshire? CONCORD

11. What is the capital of the state of New Mexico? SANTA FE

12. What is the capital of the state of New York? ALBANY

13. What is the capital of the state of New Hampshire? CONCORD

14. What is the capital of the state of New Jersey? TRENTON

15. What is the capital of the state of New Mexico? SANTA FE

16. What is the capital of the state of New Hampshire? CONCORD

17. What is the capital of the state of New Jersey? TRENTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified or requested to examine the deceased.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22657	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Goldie E. Steward						8-16-83			12 ⁵⁰ A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		Cau.		4-9-1904			79 YRS.				
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Va.		U.S.A.					TALBOT			Memorial	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Henderson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Steele Road 21640		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Gilbert Breedon		Ada Corbin									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
no		227-07-8566		Hazel Hignutt			Henderson, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 myocardial Infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic Cardiovascular Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/15/83 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE D. J. D.	
22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED 8/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS John Thomas Divilio, M.D., Box 822								22f. ADDRESS Easton, Md 21601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-18-83		23c. NAME OF CEMETERY OR CREMATORIAL Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro COUNTY STATE Caroline Md.				
24. FUNERAL DIRECTOR NAME John E. Boulais Greensboro		25a. DATE REC'D. BY REGISTRAR AUG 22 1983 25b. REGISTRAR'S SIGNATURE John J. Conner									

8/18/81

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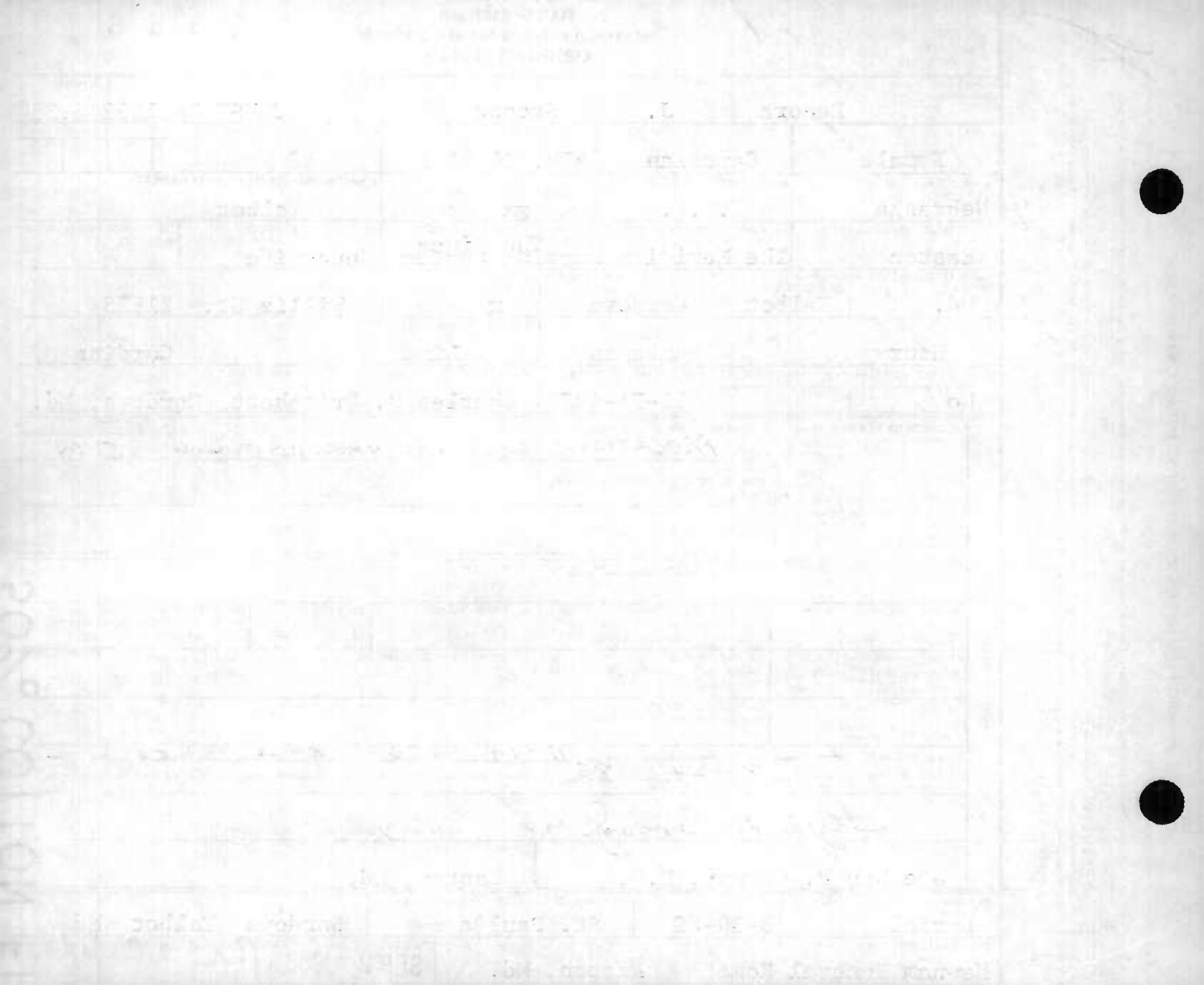
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 2 2 6 5 8			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR		
Lenora J. Stoops						AUGUST 28, 1983					6:35 ^a M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female		Caucsian		APR. 18 1885		98					YRS.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					MD.		
Nebraska		U.S.A.				Talbot							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Easton		The Meridian Nursing Center		Housewife									
13a. STATE Md.		13b. COUNTY Talbot		13c. CITY OR TOWN Cordova		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Willis St. 21625					
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST		
Henry				Hunteman		Lina					Cording		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		213-74-4272		Charles G. Pritchett		Cordova, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROGRESSIVE CEREBRAL VASC. INSUFFICIENCY</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YR.	
4379 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any: (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>11-17</u> , 19 <u>76</u> to <u>8-28</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>8-24</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE <u>Stephen P. Carney, M.D.</u>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF <input type="checkbox"/>	PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Stephen P. Carney, M.D.		Easton, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-30-83		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's		23d. LOCATION CITY OR TOWN Cordova		COUNTY Talbot		STATE Md.			
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.				25a. DATE REC'D. BY REGISTRAR'S SIGNATURE SEP 2 1983 <u>John G. Carney</u>							



15

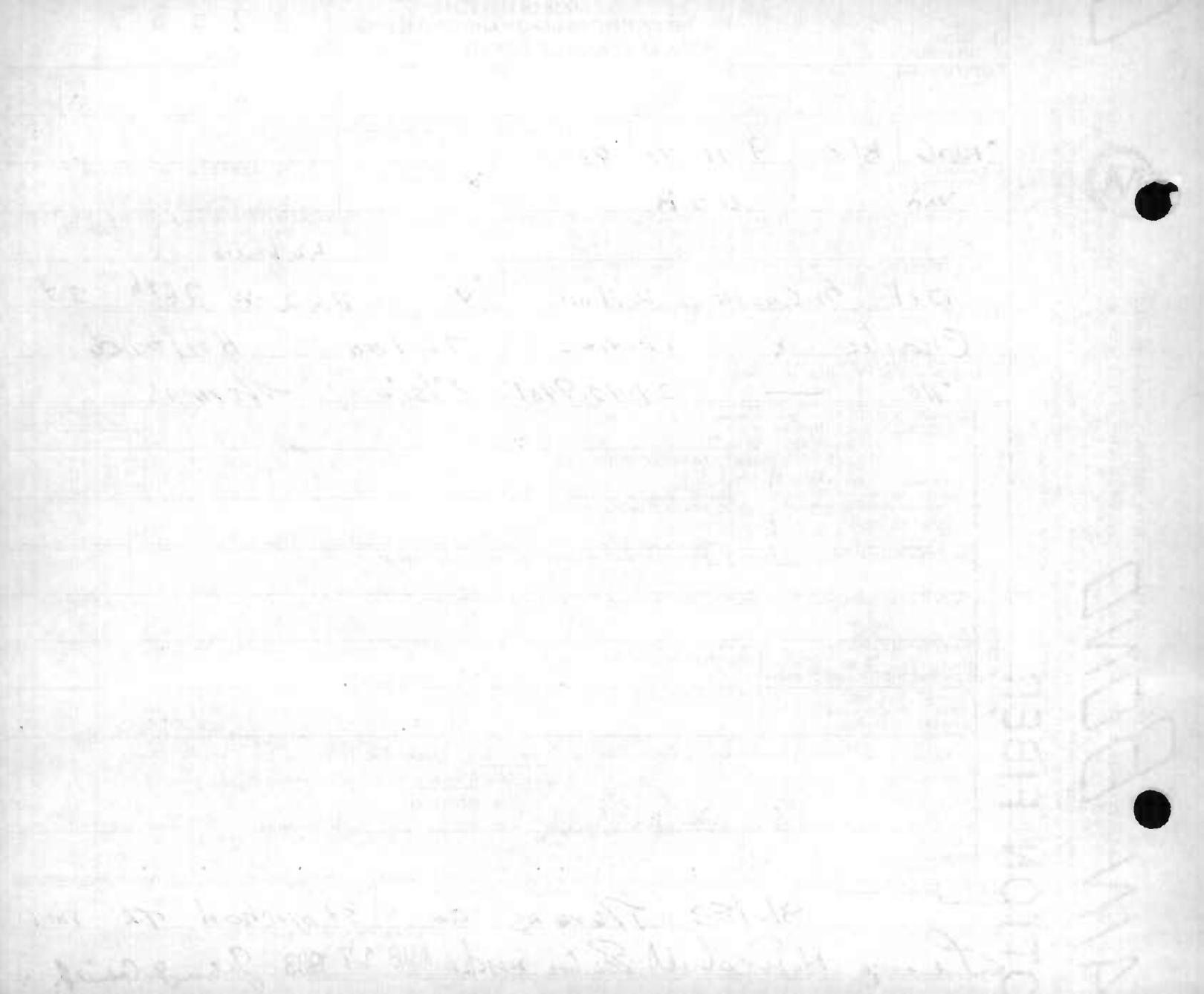
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22659

REG. NO. _____

1 - STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)						LAST				2a DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR	
		FRANKLIN		THOMAS				<input checked="" type="checkbox"/>		8 3 19 83		M		24 HOUR 6:52			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YR. MONTHS DAYS		8 IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
M		Blk		9 11 41		41 yrs.						8 3 19 83		P M			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11b. CITIZEN OF WHAT COUNTRY?		12. MARRIED WIDOWED		13. NEVER MARRIED		14. DIVORCED		15. BALTIMORE CITY OR COUNTY OF DEATH		16. KIND OF BUSINESS OR INDUSTRY					
Md		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Talbot County		Md.					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Easton		Memorial Hospital						40 hours				99999					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		202 W. 26th St							
Del		N. Castle		Wilm		<input checked="" type="checkbox"/>		ADDRESS		Holland							
FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		Elsie				Thomas					
Charles		R		Thomas		Thelma											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
No		214-42-9401		Elsie		Thomas											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9660 IMMEDIATE CAUSE (a) Stab wound of chest																	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Autopsy <input checked="" type="checkbox"/>			Inspection <input type="checkbox"/>			Inquiry <input type="checkbox"/>			and in my opinion		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		Subject stabbed.			CITY OR TOWN			COUNTY			STATE		
		Sunset Bar		Fremont St.								Talbot			Md.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>Margarita A. Korell</i> M.D. Assistant MEDICAL EXAMINER																	
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/16/83		23c. NAME OF CEMETERY OR CREMATORIAL Tum		23d. LOCATION CITY OR TOWN St. Michael		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 17 1983		25b. REGISTRAR'S SIGNATURE <i>James J. Cawley</i>											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL ALONG WITH FORM PM. 3. RETAIN PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5, WHICH SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and the medical examiner must be pointed out.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22660							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
EVELYN SEWELL									TURPIN			8 8 83						100 P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 1 HRS		9. IF UNDER 1 MIN				
female		white		MONTH 12 DAY 8 YEAR 1893			89			YRS.			MONTHS		DAYS		HOURS		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			13. BALTIMORE CITY OR COUNTY OF DEATH			14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			15. KIND OF BUSINESS OR INDUSTRY						
Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			TALBOT MD.			homemaker									
16. CITY OR TOWN OF DEATH		17. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			19. STREET ADDRESS / ZIP CODE				
EASTON		MEMORIAL HOSPITAL, EASTON										Md. COUNTY Dorchester CITY OR TOWN Salem			21835				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE									
Md.		Dorchester		Salem															
14. FATHER'S NAME			15. MOTHER'S MOTHER'S MIDDLE NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS							
FIRST Charles			LAST LeCompte			219-36-5404			James E. Turpin			21835							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. DUE TO, OR AS A CONSEQUENCE OF			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
no			219-36-5404			Cerebral Atherosclerosis													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
1629																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.																			
16e. DATE OF OPERATION			16f. CONDITION FOR WHICH OPERATION WAS PERFORMED			16g. AUTOPSY?			16h. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>8/3</u> , 19 <u>83</u> , to <u>8/8</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>8/3</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
22d. PHYSICIAN'S NAME			22e. ADDRESS																
P. GREGG RHODES MD.			400 Dutchman's Lane, Easton, Md 21601																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY STATE							
burial			8/10/83			Dorchester Mem. Pk.			Cambridge Dor. Md.										
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
THOMAS FUNERAL HOME			CAMBRIDGE MD.									John J. Coughlin							
						AUG 18 1983													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22661

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
James F. Warrington						8 05 83				3:00 PM	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White	7	10	14	69	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
DELAWARE		U.S.A.					Talbot				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Easton		Memorial Hospital			Chicken Farmer			99999			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Delaware		Sussex	Selbyville		RT 1 Box 34						
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST				
James			Warrington	Anna			Lynch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS				
NO		222-24-1847			Amanda Warrington, Selbyville, DE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Disseminate histoplasmosis</u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WKS											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Polycystic kidney disease w/ ch. renal failure</u> 9 yrs											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (We) attended the deceased from <u>41</u> 19 <u>74</u> to <u>815</u> 19 <u>83</u> , that (I) (We) last saw the deceased alive on <u>815</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.											
22b. SIGNATURE <u>Donald T. Lewers MD</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>8/5/83</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Donald T. Lewers, M.D.		Rt 3 Box 106 Easton, MD 21601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		COUNTY	STATE		
Burial		8-8-83	Roxana Cemetery			Roxana, Sussex, DE					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Charles W. White, Selbyville, Del.		AUG 16 1983			John J. Conroy						

